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THE IMPLEMENTATION OF THE GLASGOW WOMEN'S HEALTH POLICY: A CASE-STUDY OF MULTI-AGENCY WORKING

Catherine Ann Kennedy

A thesis submitted for the degree of Doctor of Philosophy to the Department of Urban
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Abstract

Multi-agency working as an approach to tackling complex and inter-related problems has increasingly been advocated in recent years in a variety of policy contexts. The research in this thesis concerns the development and implementation process of one such policy, the Glasgow Women's Health Policy. This Policy was developed by the Glasgow Healthy City Project Women's Health Working Group and is based on a social/holistic model of health. The research analyses, as a case study of multi-agency working, the process through which the Women's Health Policy was implemented, and identifies the enablers and barriers to that process.

The research consists of a retrospective analysis of the implementation of the Women's Health Policy within the statutory sector partner organisations of the Glasgow Healthy City Project. Using a qualitative approach, the research involved three primary methods of data collection: semi-structured interviews, documentary analysis and observation. Fifty-seven interviews were conducted with a range of key informants from the statutory sector organisations, which provided the main source of data.

The analysis identifies a range of action associated with the development and implementation of the Women's Health Policy by the Women's Health Working Group and statutory sector organisations. The implementation process of the Women's Health Policy was enabled by: the collaborative development of the Policy; the agency of key individuals with access to power; and the establishment of women's fora within the organisations. Barriers to the process included the marginalisation of both 'women's issues' within gendered organisations, and the social/holistic model of health in relation to the dominant biomedical paradigm prevailing within organisations. In addition a range of other impediments relating to organisational structures and cultures were identified as being common to all policy implementation. The thesis concludes by highlighting the centrality of power and agency to the implementation of the Women's Health Policy and to the process of multi-agency working.

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Abbreviations

AGoWI	Strathclyde Regional Council Advisory Group on Women's Issues
APTs	Areas of Priority Treatment
CFWH	Centre for Women's Health
COM	Community groups
Commiss.	GGHB Commissioning
CWHC	Clydeside Women's Health Campaign
EDU	University and colleges
ERDF	European Regional Development Fund
ESF	European Social Fund
EU	European Union
Exec.	GGHB Executive Board Members
GDC	Glasgow District Council
GGHB	Greater Glasgow Health Board
GHCP	Glasgow Healthy City Project
HCP	European Healthy Cities Project
Health P	Health Promotion Department
HFA2000	Health for All 2000
HIBG	Strathclyde Regional Council Health Issues Based Group
LGMB	Local Government Management Board
MCAP	European Healthy Cities Project Multi-City Action Plan
MISC	Attendees at fora meeting not associated with other categories (such as visitors, speakers)
Public H	GGHB Public Health Directorate
SRC	Strathclyde Regional Council
UN	United Nations
UP	Urban Programme
VOL	Voluntary sector organisations
WC	Glasgow District Council Women's Committee
WGWHP	Glasgow District Council Working Group on Women's Health Policy
WHAG	Women's Health Action Group
WHFWG	Women's Health Fair Working Group
WHO	World Health Organisation
WHP	Glasgow Women's Health Policy
WHPWG	Greater Glasgow Health Board Women's Health Policy Working Group
WHWG	Women's Health Working Group
WSPHG	West of Scotland Politics of Health Group

Chapter 1 - Background to the research

1.1 Introduction

In recent years multi-agency working has increasingly been advocated as an essential approach to tackling complex and inter-related issues in a variety of policy contexts. Approaches to multi-agency working have taken a variety of forms and developed for a number of reasons. In Britain one of the more established forms has been the development of partnerships for urban regeneration and local economic development. More recently multi-agency approaches have been developed in the context of community care and in work on domestic violence. Outside this formal policy context, inter-agency work and inter-disciplinary research have long been advocated by both the women's health and the new public health movements.

The multi-agency literature explores the motivations for and processes by which organisations seek to work together, identifying a range of enablers and barriers encountered. This thesis contributes to this debate through a case-study approach, using the example of the implementation of a multi-agency policy in Glasgow, the Glasgow Women's Health Policy.

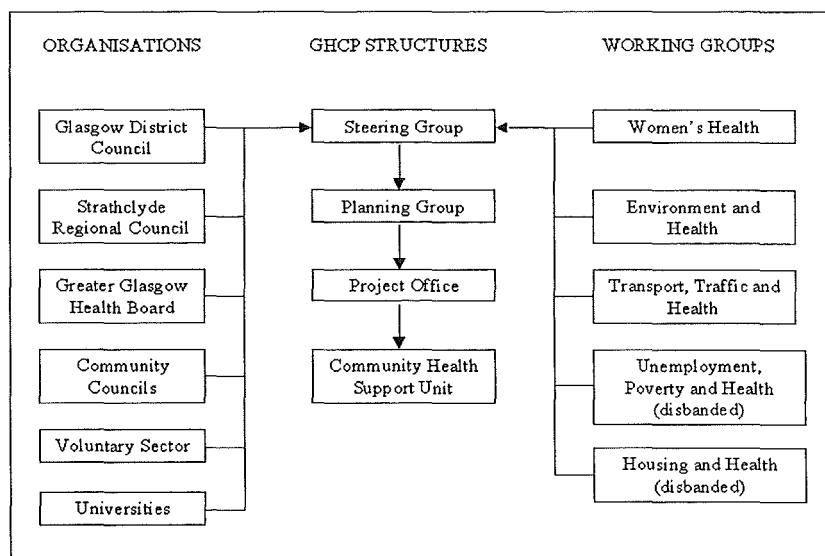
The Glasgow Women's Health Policy is of particular interest because it represents an attempt to implement a social model of women's health within local agencies which at this time is unparalleled in the UK. In addition, the literature relating to the implementation of 'gender inclusion' strategies predominantly focuses on implementation within single-agency rather than multiple agency structures. As such this research contributes to the under-researched gendered dimensions of multi-agency working.

This chapter begins with a brief overview of the case study, the content of the Women's Health Policy, and the significance of exploring multi-agency working. This is followed by an elaboration of the research aims, methodology and design; the conceptual framework, and the key definitions used; and the themes explored within the thesis. Finally, the structure of this thesis is set out.

1.2 The Case-study

This research focuses on the implementation process of a multi-agency policy which was developed within a multi-agency framework by the Women's Health Working Group (WHWG), a subgroup of the Glasgow Healthy City Project (GHCP). The GHCP comprises of representatives from a variety of organisations in Glasgow, including the three statutory sector organisations, Greater Glasgow Health Board (GGHB), Strathclyde Regional Council (SRC), and Glasgow District Council (GDC), the universities in Glasgow and a range of voluntary organisations and community groups. The development of the Glasgow Women's Health Policy (WHP) was the culmination of years of advocacy for a women's health perspective to be included within policy development and implemented within organisations, and for women's health needs to be acknowledged by the service providers in Glasgow. This work began in 1983 with the organisation of the Glasgow Women's Health Fair, and after several years of campaigning, became more formalised following the city's membership of the World Health Organisation (WHO) European Healthy Cities Project in 1988, when the Women's Health Working Group was established in 1990 as a sub-group of the Glasgow Healthy City Project. Figure 1.1 details the GHCP organisational structure.

Figure 1.1: GHCP Organisational Structure

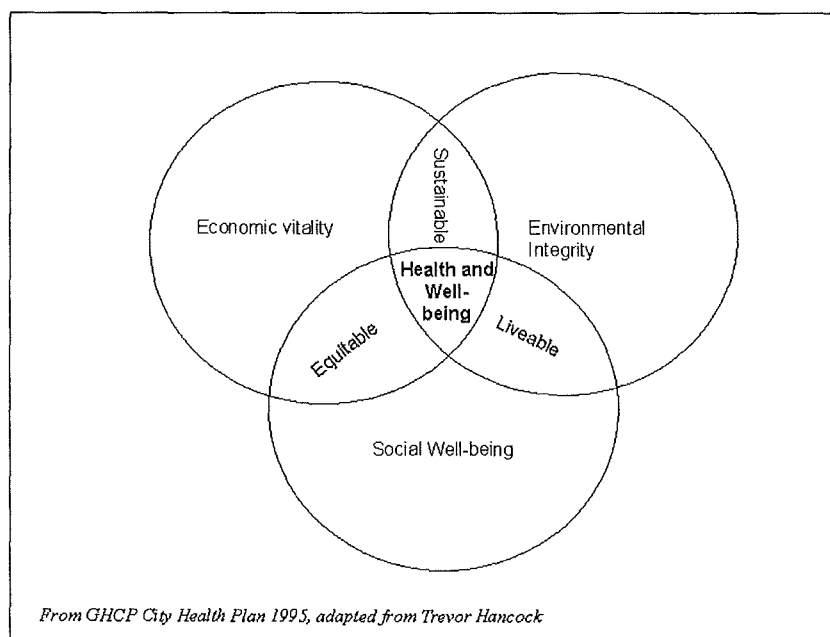


The Healthy Cities Project is based on a holistic model of health and represents a strategic attempt to implement the principles of 'Health for All by the Year 2000' (HFA2000). Within this movement health is seen as having a wide range of determinants and is not the sole concern of the health and medical services. Health is defined as,

A state of complete physical, mental and social well-being, and not merely the absence of disease and infirmity. (WHO 1948)

Thus health is defined positively as the presence of certain qualities in life rather than negatively in terms of illness or disease, and subjective assessments of emotional and mental well-being are included alongside objective measures. Health is also considered to be influenced by a variety of social and economic factors rather than merely the consequence of individual behaviours. This model of health is commonly represented as the intersection of three inter-related spheres of influence: social, economic and environmental, as detailed in Figure 1.2.

Figure 1.2: Model of Integrated Action for the Creation of Health



Determinants of health are seen to include factors such as employment opportunities, education, housing and environmental factors; inequality in general. Working with such a broad definition of health necessitates a multi-agency approach in policy, planning and service provision if the objectives of the project are to be achieved.

The Women's Health Working Group, one of the subgroups of the GHCP, acts as a network between the participants, to discuss the needs of women and the activities of the service providers, and to work to ensure that the needs of women are taken into consideration in policy planning and implementation. One of the first tasks undertaken by the WHWG was to develop a Women's Health Policy. It was felt that a health policy specifically for women was needed because of the unique health needs of women as a consequence of their social and reproductive roles, and the central role that many women have in promoting health in their families and communities.

1.2.1 The Women's Health Policy

The Women's Health Policy for Glasgow incorporates the framework for health contained within Healthy Cities, and was launched in 1992 following a period of consultation with organisations and the community. The aim of the Policy is **to improve the health and well being of women in Glasgow**. The policy contains the following objectives:

- To raise awareness about women's health needs and an understanding of a women's health perspective.
- To introduce this awareness into policy and planning processes of statutory and voluntary agencies.
- To ensure that women's health needs and a women's health perspective are incorporated into the delivery of all services.
- To ensure the provision of services and support specifically for women.

Thirty-four recommendations were made within the Policy itself, the intention being that the participating groups and organisations and their various departments would assess which of the recommendations were applicable to them and how best they could go about

implementing the strategy. A copy of the Women's Health Policy can be found in Appendix 1.

The statutory sector organisations in Glasgow formally adopted the Policy in 1992 and agreed to its implementation. In accordance with one of the 'Priorities for Action' contained within the Policy, fora to oversee the implementation of the WHP were identified or established within the statutory partner organisations: the Women's Health Policy Working Group (WHPWG) in Greater Glasgow Health Board; the Working Group on Women's Health Policy (WGWHP) and latterly a Women's Committee (WC) within Glasgow District Council; and the Health Issues Based Group (HIBG) of the Advisory Group on Women's Issues (AGoWI) within Strathclyde Regional Council. These fora, alongside the WHWG represent the core structures through which the implementation of the Women's Health Policy has been analysed.

In 1996, as a consequence of local government reorganisation, the composition of the statutory sector involvement with the Glasgow Healthy City Project and the Women's Health Working Group changed as Strathclyde Regional Council and Glasgow District Council were disbanded and replaced by a new unitary authority, the City of Glasgow Council. Related to this event, the Women's Health Policy underwent a process of review and an updated Phase 2 of the Policy was launched in October 1996 as a means of renegotiating commitment to implementing the Policy from the new configuration of organisations.

These two events, occurring during the first year of this research have a significant bearing on the focus of the analysis. The period following local government reorganisation was one of great change as new structures were gradually established within the new unitary authority. Phase 2 of the Policy also represented a reappraisal of the focus for action on women's health based on past achievements and a developing understanding. Due to the period of flux associated with these transitions, the focus of this research became a retrospective analysis of the first phase of the Women's Health Policy and its implementation within the original three statutory sector organisations between the years 1992 and 1996.

1.2.2 Why multi-agency working?

As will be seen throughout the forthcoming analysis, multi-agency working is a concept central to the development and implementation of the WHP, and the WHO Health City Project. Multi-agency working can be seen as present in the structural arrangements of the Glasgow Healthy City Project and the Women's Health Working Group through the involvement of representatives from a variety of agencies in Glasgow. Multi-agency working was also employed in the development of the Women's Health Policy by the Women's Health Working Group, in the consultation of organisations and women in Glasgow, its adoption by the partner agencies and the desired approach to implementation. However, despite its centrality to the development of action on health in the city, the term 'multi-agency' is itself rarely used within the documents. Rather there exists a range of terminology which may have a common meaning, derive from a common understanding and refer to the same intended action. For example, the 1989 GHCP Position Statement highlights the important "*interrelationships*" between spheres of activity, and the importance of "*shared visions and principles*" (1989:32). Within the City Health Plan it is stated that health and well-being requires:

integrated planning and management which combines multiple aims, multiple means and multiple groups with diverse interests working towards the achievement of fundamental social and economic goals while maintaining the environmental integrity of the city. (1995:30 - my emphasis)¹

The need for organisations to work together is also highlighted in the Women's Health Policy for Glasgow, which includes as a 'Priority for Action' the direction that each partner organisation should

Improve inter-agency co-operation by ensuring representation on the Women's Health Working Group. (1992:9 - my emphasis)²

The Women's Health Policy also contains the following recommendations in relation to the four objectives:

¹ Glasgow Healthy City Project (1995) *Working Together for Glasgow's Health: Glasgow City Health Plan 1995* (Glasgow : Glasgow Healthy City Project) pp.31

1.2: Consult with representative women's groups and organisations and take account of their views in decision-making (1992:5 - my emphasis)

2.2: Develop inter sectoral planning for women's health (1992:6 - my emphasis)³

Thus within this limited range of examples a range of terminology can be seen, for example, 'inter-agency', 'inter-sectoral', 'co-operation', 'interrelationships', 'shared visions', 'integrate planning and management', 'consultation'. This plethora and ambiguity of terminology is reflected in the literature reviewed in Chapter 2. What is clear however, within these policies and statements, is the emphasis of multi-agency action for the improvement of health, and in the case of this research, women's health in particular.

1.3 Research aims

This research has been conducted as part of an ESRC CASE studentship, co-sponsored by the Greater Glasgow Health Board. As such the research area was broadly defined by my PhD supervisors prior to my involvement in the research. The research is based on three core aims, which have formed the research questions for analysis.

- 1. To examine the extent to which the Women's Health Policy has been adopted and implemented by the Healthy Cities agencies.*
- 2. To identify the factors, both social and organisational, which have facilitated or hindered the implementation of the policy.*
- 3. To describe and analyse the processes involved in multi-agency working.*

Each of these research aims are addressed within the subsequent chapters of this thesis. However a number of points of clarification need to be made which can be examined through a summary of the research methodology and design.

² Glasgow Healthy City Project Women's Health Working Group (1992) *Women's Health Policy for Glasgow* (Glasgow: Glasgow Healthy City Project).

³ Glasgow Healthy City Project Women's Health Working Group (1992) *Women's Health Policy for Glasgow* (Glasgow: Glasgow Healthy City Project).

1.4 Research methodology

This research utilises an inductive approach to the analysis of the case study. As such the research does not begin with a prior hypothesis to be tested in the course of the analysis, but rather is based in a number of broad research questions or aims from which it is intended to generate an explanatory theory of the processes associated with the implementation of the Women's Health Policy. This was deemed to be the most appropriate research strategy due to the absence of any known research addressing the gender dimensions of policy implementation or multi-agency working in the context of a holistic model of health. The research proceeds from an interpretivist stance, exploring the social construction of 'reality', rather than a search for 'social facts'. As such the emphasis is on the perceptions of the interviewees, and their interpretation of events. This framework shapes the form of the analysis as is detailed below.

In relation to the first research aim, to examine *the extent to which the Women's Health Policy has been adopted and implemented by the Healthy Cities Agencies*, 'extent' is not deployed as a rationalist or 'top-down' approach in terms of evaluating the effectiveness of the Policy, the degree of success or failure. Such an approach was not considered desirable or feasible given the retrospective focus of this analysis, the absence of any base-line data by which to compare action before and after the adoption of the Policy, and the lack of an appropriate research methodology by which to 'measure' the subjective assessments central to a model of health and well-being (Davies and Kelly 1993). Rather, examination of the extent of implementation is reviewed in the course of analysing the implementation *process*, both through documentary analysis and the perceptions of the interviewees.

In approaching the analysis of *the factors, both social and organisational, which have facilitated the implementation of the Policy*, as both a holistic health and a multi-agency policy a number of issues were researched, including the status of the document as a 'women's' policy, the influence of organisational cultures and structures, and issues of power, agency and interests. These issues were also employed in addressing the third research aim, to *describe and analyse the processes involved in multi-agency working* in analysing the processes involved in the context of the interviewees' experiences of the

Women's Health Policy and also their more general experience. The research findings were then reviewed in the context of the literature available.

1.5 Research design

The focus of this research concerns the implementation of the WHP within and between the statutory partner agencies, through the WHWG and the organisational women's fora previously identified. This decision was taken for a number of reasons. Firstly these organisations were the funding partners of the Glasgow Healthy City Project, and also the main service providers and decision-making agencies in Glasgow. As such their status within the multi-agency arrangements differed to that of the other representative groups and organisations: their co-operation was vital to the implementation of the Policy and they can be characterised as the 'lead' agencies, essential to encouraging or sustaining the implementation of the Policy within the other member organisations and groups.

The second reason relates to the differences in participation and involvement between the statutory organisations and other sectors involved with the Women's Health Working Group and the implementation of the Policy. Voluntary sector representation to the WHWG came from a wide variety of organisations but tended to lack the continuity of attendance or involvement associated with the statutory sector organisations. Similarly the involvement of the community sector with the WHWG was virtually non-existent after 1990. During the course of conducting the interviews with voluntary and university sector representatives it became apparent that implementation of the Policy was, in the main, not occurring beyond the involvement of the individual representatives. No structures had been established to oversee the implementation of the Policy, as there had been within the statutory sector organisations, which provided at least a formal mechanism through which the implementation of the Policy could be analysed. This rendered comparative analysis of the implementation *process* between these sectors and the statutory sector organisations problematic. However, the apparent lack of the development of the Policy within these organisations in the absence of established structures is a finding in itself. The *process* of implementing policy was most evident within those organisations which had developed structures to facilitate communication, priority setting and decision-making. This is not to

say that the WHP has not been influential or implemented in other settings; rather, in the absence of structure, the analysis of process is less accessible to research.

1.6 Theoretical framework

In this case study, which employs an interpretivist stance and a qualitative method, the conceptual framework employed in this research is best described as social constructionist. Social construction theory, according to Jackson and Penrose (1993) is “*concerned with the ways in which we think about and use categories to structure our experience and analysis of the world*” (1993:21). As such, it is argued that there is no objective reality ‘out there’ waiting to be identified. Rather, as Bacchi (1996) argues, categories are ‘real’ insofar as they act as “*signifiers in the ‘real’ world*”, but are also “*constructs, reflecting specific combinations of historical and political experience*” (1996:3).

In addition, two theoretical perspectives have been informative within the analysis: socialist feminism and post-structuralist feminism. Socialist feminism combines consideration of the influence of capitalism and patriarchy on the production and reproduction of socially constructed gender roles and inequality, and emphasises the role of power with the “*analytic integration of social structure and human agency in the persistence of gender segregation and gender oppression*” (Calás and Smircich 1996:233). Whilst recognising the diversity of identity and experience in relation to class, ethnicity and sexuality, an arguable limitation of this perspective is the modernist binary opposition of the ‘sex-gender system’ - the association of socially constructed gender roles with biological sex, leading to a universalised category of ‘women’ in opposition to ‘men’. In addition, as a structuralist perspective, socialist feminism has been criticised as too deterministic and identifying limited opportunities for change short of a social revolution. For these reasons, post-structuralist feminism provides an insightful critique.

Post-structuralist feminism, particularly that derived from Foucault and discourse analysis, focus on the processes, as opposed to origins, through which gender hierarchies are constructed and legitimised (Scott 1988). Central to this perspective is the questioning of the existence of objective knowledge, and the universalism and essentialism of modernist feminist theories in their construction of unitary subject positions such as ‘women’.

Rather, in highlighting the production of knowledge/power relations through discourse and practice, space is created for the existence of subjectivities and asymmetrical power relations, and the diversity of subject positions (Calás and Smircich 1996).

Both of these theoretical perspectives have been insightful in developing the analysis within this thesis. A central concern of the research involves an analysis of the relationship between structures and agency in the processes associated with the implementation of the Women's Health Policy and multi-agency working. Socialist feminism offers the ability to contextualise these features within the dominant discourse operating in society. However, as noted above, structuralist accounts often lend themselves to deterministic conclusions. Post-structuralism provides an important critique of these accounts and useful analysis of the role of power, culture and agency, and as a corollary opens up notions of resistance through alternative discourse to the over-determinism of structure. Whilst not adopting post-structuralism wholesale, it is argued that it opens up the scope for debate and provides a framework politically more instrumental to the possibility of change.

1.7 Key definitions

In order to clarify the framework for the analysis within the subsequent chapters some elaboration of the key concepts employed within the research is required: 'health', 'multi-agency working', 'women' and 'gender'.

The definition of health employed within the research is in line with the positive, holistic definition of health deriving from the 1948 WHO definition of health which forms the basis of the Healthy Cities Project. This definition, whilst open to criticisms of being an unachievable utopian ideal (Hancock 1992) is not problematised within the research.

Multi-agency working, in the absence of precise meaning derived from the literature, is used as an umbrella term to denote the variety of different ways in which a range of organisations work (or seek to work) together, at a number of different levels. The literature utilises a variety of terms relating to inter-organisational working, such as collaboration, inter-agency, co-operation, and joint working, which are often undifferentiated or used synonymously (Huxham 1996). In addition whilst multi-agency

working is considered central to the development of health within the literature on the Healthy Cities Project, this term is seldom used directly, but rather a variety of differing terms relating to organisations working together. It is not the intention of this research to develop a more precise definition of multi-agency working - this would arguably be inappropriate within the context of a single case-study. Rather, the concept is used as a vehicle to understand the processes involved in implementing the Policy and the factors which have enabled and hindered that process.

Concepts of 'women' and 'gender' are central to this analysis due to the labelling of the policy as 'women's' and the context of its implementation within 'gendered' organisations. These two concepts are frequently conflated in a variety of ways. Within some academic and policy literature 'women' and 'gender' are used synonymously: for example, accounts of 'gender and organisations' and 'gender and health' use 'gender' in discussing women's experience generally excluded within the mainstream literature. In some instances this usage is arguably inadequate as the critique neglects an examination of 'men'. Secondly 'women' as a biological sex is often directly correlated to assigned gender roles rather than challenging this binary opposition or recognising the multiplicity of 'gender' positions.

Emphasis is given within this research to the social construction of gender and of the category 'women'. In relation to the concept of 'gender', whilst agreeing with the need to separate socially constructed gender roles from the biological base as a means of highlighting their status as constructions and thus open to change, and in order to recognise a diversity of gender positions, acknowledgement is given to its common usage as a signifier of the relations between 'men' and 'women'. As an example the term 'gender inclusion' is used within the thesis to denote strategies and action seeking to promote women's equality or parity within male dominated organisations and society.

The category 'women' is also viewed as a social and political construct. The category 'women' has been the subject of increasing debate within feminism, with developing critiques that in seeking to highlight the commonalities, the diversity of experience between women is not acknowledged, as differences of class, ethnicity, age, sexuality and disability are subsumed within the universalism of 'women' (Bacchi 1996). This critique

creates a tension between theoretical understandings and the practices of seeking to develop the legitimacy of the category as a locus for developing action for 'women' as a group.

Several authors point to the limitations of employing the category 'women' as a focus for change. Bacchi (1996) notes that the binary opposition employed leads to a narrow focus on 'women's difference' or 'sameness' to men. In addition Bacchi (1996) highlights through her research on affirmative action the 'disturbing commonality' across countries of the limited importance afforded to women as a political category, noting that when the category gains status this is often associated with political manoeuvre to limit its effectiveness. Riley (1988) questions the usefulness of the category as a 'rallying point' for progressive change as a result of the meanings attached to it historically and culturally, where 'women' is "*imbued in all political languages with domesticity in a broad sense*" (1988:66).

However, as Bacchi (1996) notes, the category 'women' exists within discourse and thus feminists have no option but to engage in debating its meaning. She locates the 'appearance' of essentialism within the category to women's marginalisation within discourse and the necessity for feminists to impose definition as a means of legitimating their calls for the increasing representation within the sites of discourse production: government, academia, trade unions etc. As such, she argues that category 'women' should be viewed as "*practical and strategic rather than ontological*" (1996:11)

Thus within this research it is argued that gender and the category 'women' are social constructs. As a result notions of 'gender difference' and 'gender inequality' are similarly conceived of as social constructs. This is not to imply that gender difference and gender inequality do not exist in the lived experience of women and men, rather that difference and inequality are socially, culturally and historically produced and thus open to change as opposed to innate and immutable. Similarly, in highlighting the category 'women' as a social and political construct open to criticisms of false universalism, this is not to dismiss the political salience of the category as a focus for change. Rather, it is argued, with Bacchi (1996), that in developing an awareness of the social construction of the category,

the task is to work with the category, to challenge the meaning and value ascribed within dominant discourse. As Bacchi (1996) notes

The message is that feminists must continue to insist upon the political relevance of 'women', but contest interpretations and deployments of the category which minimise progressive developments for women and other outgroups...that feminists contribute to the construction of new uses for the concept. (1996:13)

In discussing the aforementioned terms within the analysis, following Butler (1992), acknowledgement of the contested status of the terminology is indicated through the use of inverted commas.

1.8 Central Issues

The research findings demonstrate the inter-connections of concepts, language and culture; of agency and power played out within a framework of structures which have acted in contrasting ways as both enablers and barriers to the implementation process of the Women's Health Policy.

The development and implementation of the WHP within the statutory sector organisations has led to a significant number of developments and range of action which arguably would not have occurred otherwise. Significant amongst these have been the development of women's fora within two of the organisations, the multi-agency funding of the Centre for Women's Health, the expansion and improvement of services, the production of research and information, and the organisation of training, conferences and seminars. Beyond the formal structures and funding however, much of the action has been dependent on a core group of women rather than being progressed independently within the mainstream structures. This has been a result of the marginalisation of the WHP and women's structures, their lack of power and also the difficulties experienced by organisations in trying to work together.

In relation to the concept of health employed within the Policy and the Glasgow Healthy City Project, this at one level acts as an enabler as it opened up the field for debate of what 'health' is, and for the inclusion of 'women's health' as a legitimate concern within those

debates. However barriers are also present in vested interests in maintaining the status quo, related to structure, and issues of remit and responsibility. The operation of bureaucratic, hierarchical and functionally differentiated organisations limits the extent of development and inclusion of a social/holistic model of health. The particular cultural context, and the dominance of the biomedical paradigm is also of significance: whilst there exists a theoretical understanding of a social/holistic model of health, this is not translated into a practical understanding of its relevance or how to operationalise it.

The labelling as 'women's' policy is also conversely identified as an enabler and a barrier. 'Women' as a category acts as a collective rallying point for political action on issues of concern to members of that category. However, the category 'women' within its definition fails to acknowledge the diversity of experience amongst women in the construction of an homogenised 'woman'. In addition due its position within discourse as subject 'other' this is seen to result in the marginalisation of women's issues and structures from the mainstream of organisations, remaining an additional issue outside dominant discourse. This relates to the exclusion of a social/holistic concept of health in being outside the dominant discourse shaping organisational practice.

Multi-agency working highlights similar enablers and barriers in relation to the implementation process existing between as within organisations. The analysis presented here indicates the important role of culture, interests, power and concepts as well as structural barriers to co-operative working between organisations. The research demonstrates the resilience of organisational structures to change as a result of vested interests located in the dominance of professionals and departments/organisations seeking to maintain their power base and autonomy. It is argued that location of power and agency are the key determinants of the enablers and barriers to the implementation of the Women's Health Policy and multi-agency working in general.

1.9 Structure of the Thesis

Given the broad scope of analysis within this thesis relating to the implementation of a holistic model of health within a multi-agency context, a diverse range of literature has been drawn upon in this study and is reviewed in Chapter 2. This includes a review of the

literature on new public health and women's health movements; policy development and implementation; approaches to gender inclusion within organisations; and multi-agency working.

Chapter 3 details the research design and methodology employed. This has been a qualitative, empirical analysis using an inductive approach, and informed by socialist feminist and post-structuralist feminist perspectives. The research utilised three methods for data-collection: semi-structured interviews, documentary analysis and observation. The strengths and weaknesses of the varying approaches within the context of this research are discussed.

The context of the development and implementation of the WHP is explored in Chapter 4. This explores the progression from informal action outside the main organisations in Glasgow to become more formalised through the city's membership of the Healthy Cities Project. The chapter also explores the evolving focus of concerns relating to women's health and the competing explanations contained within the Women's Health Policy. This is followed by an exploration of the processes through which implementation of the Women's Health Policy was approached within the statutory sector organisations, through the Women's Health Working Group and organisational women's fora using documentary analysis and interview data. In analysing the structures, membership, roles and priorities of these fora a variety of enablers and barriers within the implementation process are identified which are explored in further detail within the two subsequent chapters on the enablers and barriers to the implementation of the Women's Health Policy.

Chapter 5 highlights the action that has taken place in relation to the WHP, and analyses the perceptions of the interviewees as to what factors or circumstances had enabled the implementation of the Policy, highlighting issues of access to power, informal action and agency. Chapter 6 approaches the implementation of the Policy from the opposite angle - the perceived barriers to the process. Central to this chapter is the gendered nature of organisations and the consequences resulting from attempts to introduce notions of equality within such culture and structures. The interviewees' perceptions of barriers to the implementation of the Policy are analysed, locating issues of marginalisation, lack of

power and agency and cultural and structural barriers within the statutory organisations. Attention is drawn to the 'problem representation' approach to policy analysis developed by Bacchi (1999) to consider how the 'problem representation' contained within the Policy may influence the proposed interventions and ultimately the resulting implementation. Attention is drawn to the relative absence of the Policy and the Women's Health Working Group from discussions of multi-agency working. This is argued to result from the status of the group as a voluntary rather than a statutory arrangement, the lack of clarity given to the obligations and responsibilities of the organisations and their representatives, and the marginalisation of women's health within the organisations

Chapter 7 draws together the varying themes identified within the analysis, concluding with the importance of structure and culture as enablers and barriers to the implementation of the Women's Health Policy.

As a final note to the reader, clarification is needed of the approach to referencing within the thesis. The use of footnotes denotes reference of documentary analysis. The literature reviewed is identified within the text and referenced within the bibliography at the end of the thesis.

1.10 Summary

This chapter has provided a synopsis of the case-study, the research aims and methods, and the key definitions and central issues. In the next chapter the available literature is reviewed.

Chapter 2 – Literature Review

2.1 Introduction

The Women's Health Policy represents a unique attempt to implement a social model of health within a local multi-agency policy context. As such it is something that is largely without precedence within the research literature. However, there exists other related literature, particularly that examining the women's health movement and the implementation of 'women's'/equality policies within organisations.

This chapter begins by reviewing briefly the literature on the new public health and women's health movements in order to place the WHP in relation to broader concepts that may have influenced its development. This is followed by a section exploring the literature on policy development and implementation, and feminist critiques of these. The range of women's policies and their development, research evidence relating to the factors affecting their implementation within organisations are then reviewed. Finally, there is a review of the literature on multi-agency working, seeking to identify its characteristics, and the enablers and barriers to organisations working together.

This chapter is not intended to provide an exhaustive review of the relevant literature. Rather it intends to highlight the main themes emerging from the literature which will be compared to the analysis of the research data collected in the course of this work.

2.2 'Healthy Cities' and the New Public Health Movement

The model of health contained within the Women's Health Policy and Glasgow Healthy City Project can be argued to represent a significant shift from the present organisation and approaches to health within mainstream health policy, but one which has historical precedents. It is also one that bears a resemblance to some women's policies and the women's health movement. For this reason, a short review of changing conceptualisations of health is included here to situate these present developments within their historical context.

The ideas contained within the WHO strategies of 'Health for All' and Healthy Cities represent a return to the 'sanitary idea' of the public health movement of the 19th Century (Ashton 1992). Growing concern over the spread of disease within rapidly expanding urban and industrialised communities led to the establishment of the Health of Towns Associations and the Health of Towns Commission in 1843 to research the poor conditions in cities. The Commission concluded that environmental factors such as pollution, bad housing, overcrowding, inadequate sanitation and poor food and water supply, created the conditions within which epidemics could thrive, and that only by addressing these factors could the health of the population be improved (Ashton 1992).

The 1848 Public Health Act provided the legislative and organisational framework for public health in Britain. As the incidence of specific disease such as cholera declined, so did the public health movement. However authors have stressed the threefold influence of this movement in creating "*an inter-sectoral coalition to work for public health*" (Ashton 1992:2), in broadening concepts of health to include external, environmental factors largely beyond individual control, and in the recognition of the influence of the social context upon health, albeit from a biomedical perspective (Martin & McQueen, 1989).

Whilst the 'sanitary idea' continued to be a central influence on public policy until the end of the 19th Century, its influence was replaced by the 'germ theory of disease' with the introduction of immunisation and vaccination which shifted the emphasis from environmental causes to personal prevention (Ashton 1992). This was superseded from the 1930s by the 'therapeutic era' with the advent of insulin and sulphonamide drugs, and until the 1970s public policy on health came to be dominated by a treatment orientated approach (Ashton 1992:3). As Martin and McQueen note, "*the individualising of health and illness has in effect removed the social dimension from the causation of disease and hence from prevention.*" (1989:4). It also led to a return to a 'disease specific causality', seeking to identify single causes of ill-health rather than looking at the broader picture.

It was against this context of the medicalisation of health that the NHS was established through the 1946 Health Service Act, operationalised in 1948 (Jones 1994). The

development of the NHS provides an illuminating example of the power the medical establishment wields not only in defining health but the form the delivery of health services takes. For example, as Jones (1994) notes, concessions made by Bevan, the Labour Health Minister, as a result of pressure from the medical establishment meant that doctors but no other health workers were allowed to sit on NHS management bodies. In addition, the plans to introduce health centres, which would have played a major role in preventive health work and the co-ordination of services, were shelved because of the doctors fears of coming under local authority control. Jones argues this led to a series of weaknesses being built into the NHS from the start, with the consequence that the NHS became largely a 'national *hospital* service' (1994:121) with little emphasis on the prevention of ill-health. Jones (1994) notes that it was not until a major review of the family doctor service in 1966 that the number of health centres grew significantly, and that this re-emphasis on health centres was partly in response to changing ideas about what it meant to be 'healthy'.

Awareness of the failure of the NHS to reduce inequalities in health between different sections of the population and the high costs associated with hospital based treatment led to the therapeutic era being increasingly challenged in the 1970s (Ashton 1992). Critiques of the medicalisation of health were also being increasingly developed within sociology, with arguments associated with the negative impact on the health of the population through the development of a culture of dependency on medical expertise and treatment (Illich 1975), and the removal of traditional lay health practices (Oakley 1993). In addition conflicts remained over a range of issues which had an impact on health and well-being: domestic violence, the 'double burden' for women of domestic responsibilities and paid employment, the double standards of morality for men and women, and class inequalities (Jones 1994). By the late 1960s these tensions became increasingly visible when moves by individuals to gain greater control over their bodies were accompanied by a partial backlash against the increasing emphasis on medical technology, and the presumed centrality of the medical profession to improving health (Jones 1994). It is within this context that the new public health and the women's health movements emerged.

2.2.1 Towards a New Public Health

The failure of the NHS in its intention to reduce health inequalities between classes, localities, genders and ethnic groups, combined with the growing scepticism of the ability of medicine to solve these problems led to a re-examination of the determinants of health and a search for alternative ways to reduce the inequalities of health in the population. A significant body of research developed which was influential in challenging the effectiveness of the bio-medical model in preventing illness and disease, highlighting the persistence of socially structured inequalities in health (Black Report 1980). Other research reviewed the decline in infectious diseases in Britain prior to the advent of effective therapeutic medicine and restated the importance of public health approaches (McKeown 1976). Blane (1989) highlights the success between 1870 and 1914 of 'preventive reforms' and the 'sanitary idea' implemented through central and local government in contrast to the 'health education' of the medical profession, which proved less beneficial due to its individualised, victim-blaming approach. Many of the features Blane (1989) highlights of preventive reforms in this period, such as an emphasis on local change and consideration of the needs of lay people can be found within the principles of Healthy Cities.

Whilst developing a critique of the therapeutic, treatment-based approach to health, the traditional approaches of public health, operating within a bio-medical framework, were also challenged (Davies and Kelly 1993). McQueen (1988) argues that most epidemiological research concentrates on the 'holy four' of personal behaviours: smoking, alcohol consumption, diet and exercise; and that little attention is paid to the social context in which these behaviours develop or to other behaviours which may have important influences on health. This can be seen to result from the ideological framework within which public health developed. According to Martin and McQueen,

The growing discrepancy between the received ideology about what constitutes public health and the current practice and institutionalisation of public health has led to a movement to create a 'new public health' that is concerned with both the public and health; this emphasis shifts the focus from patients and hospitals to people and their everyday life (1989 : 2)

According to Ashton (1992) the New Public Health seeks a synthesis of approaches from

the environmental, personal preventive and therapeutic eras, focusing on public policy as well as individual lifestyle and behaviour. It refocuses attention on factors largely beyond individual control, and broadens health concerns beyond health care provision. It also aims to take into consideration local needs and the views of the lay population, and to change existing professional structures.

2.2.2 Health for All and Healthy Cities

'Health for All by the Year 2000' (HFA2000) and its strategic project 'Healthy Cities' are part of a distinct attempt to operationalise the ideas and concerns of the New Public Health movement. They incorporate a definition of health that can be found in the WHO 1948 constitution, that

Health is a state of complete physical, mental and social well-being and not merely the absence of infirmity and disease. (WHO 1948).

The WHO Alma Ata Conference and Declaration on Primary Health Care (1978) was instrumental in the development of the WHO 'Health for All by the Year 2000' strategy. As Davies and Kelly (1993) have noted this strategy can be seen as a turning point in WHO activities which until this point had been underpinned by the prevailing paradigm of a 'treatment model' concerned with the development of medical technology and expertise and its export from the developed to the developing world. HFA2000 comprises a series of 38 targets to be achieved in order to improve the health of the population.

The concept of a 'Healthy City' was developed by Len Duhl, who described it as "*an attempt to look at the whole of health and cities in relationship to its parts*" (1992:15). Healthy Cities was initially developed by the WHO as a pilot health promotion project for the strategic implementation of the principles contained within 'Health for All Strategy' (1981) and the 38 targets of 'Health for All by the Year 2000' (1985), and was launched in Lisbon in 1986. As Hancock (1993) notes,

The Healthy Cities Project was conceived as a means of taking these broad concepts and strategies and applying them at the local level following, in essence, the environmental dictum of thinking globally and acting locally. (1993 : 14-15)

HFA2000 and the Healthy Cities Project move from a negative individualised concept of health to a positive and holistic concept, looking at the influence of social and environmental factors outside individual control, whilst seeking to promote peoples' agency to improve their own health status. A combination of organisational change and community participation are considered essential in order to improve the health of the population. The five general principles underpinning Health for All are:

- Equity - reduction in inequalities in health
- Empowerment - enabling individuals to reach their full mental and physical potential
- Participation - of communities in decisions affecting their health
- Co-operation - between statutory and voluntary agencies
- Local primary health care - preventive services at the community level.

The preliminary objective of Healthy Cities was to develop collaboration between the public, private and voluntary sectors in order to tackle urban health related problems in a broad way. The rationale behind the development of the Healthy City Project, according to Ashton (1992) involved the continuing urbanisation of the population of Europe and the recognition of the connection between the urban condition and the growing ecological crisis. Whilst Healthy Cities does not aim to provide a prescriptive blueprint of tested solutions, five major elements were identified as important to the Healthy Cities approach:

- the formulation of concepts leading to the adoption of city health plans which are action-based and use the principles and targets of Health for All as a framework.
- the development of models of good practice, ranging from environmental action to community lifestyle programmes.
- monitoring and research into the effectiveness of models of good practice on health and cities.
- exchange of information and ideas between collaborating and other interested cities.
- mutual support, collaboration and learning and cultural exchange between European cities (Ashton 1992:8).

The breadth of the definition of health is such that all areas of life can be seen as having an

impact on health. However, the diversity of its parts creates a number of pragmatic problems for its implementation. The impact of the urban environment on health are complex and the HCP stresses the need to embrace the diversity inherent within communities, but with this comes the problem of how to develop health policies and services to meet the multiple needs and expectations in the community (Duhl 1992).

The strategy of Healthy Cities involves the development of local projects with national and international networks in order to influence national governments and policies. Local government was also seen as an important operator in the improvement of health as they are the major provider of services influencing health and the public's main source of contact with policy makers. As Curtice (1993) notes,

A critical mass of cities in which health issues were prioritised was seen as the basis of a powerful and effective new public health lobby. City governments were identified as agents of the new public health movement because by adopting city health plans, they could demonstrate the value of making health a reference point for public decision-making (1993 : 38)

However, it has been recognised that such an approach incorporates a range of dilemmas for local government in the light of the limitations present for creating change due to many areas of policy decision and action being out with their control (Hancock 1993). As such, it is argued that in order for the objectives of Healthy Cities to be achieved adjustments are also required within the national policy framework in areas such as economic development, housing, transport and education, and a recognition of the role they have in the production of health (Flynn 1992).

Such a broad, holistic concept of health also requires the development of new research methodologies which include qualitative as well as quantitative indicators of health, recognising the importance of subjective as well as objective measures of health (Ashton 1992). However a significant problem, noted by several authors, is that ideas about the structural and environmental influences on health, and the importance of mental and emotional as well as physical health and well-being have been developed without a corresponding research methodology with which to assess this positive concept of health (Davies and Kelly 1993; Hancock 1993). It may be argued that this stems from the

tendency to see objective measures of health as the only adequate method of measurement and the dismissal of qualitative analyses of the subjective experience of health. This again stems from the medicalisation of health and the dominance of medical professionals in defining what health is.

Thus, in summary, the new public health movement and Healthy Cities can be seen as developing from a critique of the dominant biomedical paradigm and of the treatment rather than prevention based approach to health, which comprised of the medicalisation, professionalisation and objectification of health. This critique was based largely on the perceived failure of the biomedical approach to reduce inequalities in health within the population. In contrast, based on empirical research of the determinants of health/ill-health, a social/holistic model of health has been advocated for implementation which acknowledges the social, economic, cultural and environmental influences on health. Such an approach recognises the impact of structural impediments and individual agency, the importance of subjective as well as objective measures, the need for multi-agency collaboration and community participation and for the development of local and national policies.

The various changes in health policy have broadly developed in response to either the innovation of new technology or as a response to the relative failure of previous policies to improve the health of the population. As will be discussed further in Chapter 4 on the case-study, the development of the Glasgow Healthy City Project can be seen as a response to concern over the poor health record in the city. Glasgow has a death rate 11 per cent above the Scottish average, and Scotland has the second highest death rate for women, and the fourth highest for men of 17 international countries with reliable health statistics (GHCP, 1994). In addition there was an acute awareness of the inequalities in health within Glasgow, with poorest health being concentrated in areas of social deprivation. As such, it may be argued, the time was right for the development of the GHCP, with political consensus amongst statutory sector organisations in the city, that something needed to be done to tackle Glasgow's appalling health statistics.

2.3 Women's Health

Research on women's health has increased markedly since the 1970s, largely as a result of the development of the women's health movement, which arose out of the second wave of feminism in the late 1960s. Many parallels can be seen between the preoccupations of the women's health movement, the emergence of the new public health movement and the critique of medicine within sociology. Central to this has been the progression from a focus on biology and health care, to the argument that women's health can only be understood within the context of their everyday lives, and the development of, and advocacy for, a social model of health. Several authors have provided comprehensive reviews of the development, concerns and actions of the women's health movements in the United States (Ruzek 1978; Ruzek *et al.* 1997a; Zimmerman 1987), Australia (Broom 1991), Britain and the developing world (Doyal 1983, 1995), each identifying a number of stages of within the movements. Such developments reflect evolving debates within feminism more generally, as will be discussed later.

The earliest phases of the women's health movement focused on the need to 'demedicalise' women's bodies, on developing '*feminist alternatives to medical control*' as Ruzek (1978) subtitled her book on the movement. The dominance of the bio-medical paradigm, the increasing dominance of medical experts and use of technological interventions in medicine has been witnessed in most societies throughout the 20th Century, are seen to have a range of impacts of particular significance to women. For example, the normal processes of pregnancy and childbirth moved from being primarily within the domain of lay women and midwives to be reconceptualised as medical problems requiring medical intervention under the control of doctors (Oakley 1993). Other issues of concern have been the access of women to appropriate health care; the treatment of women by health care professionals within organisations that are largely male dominated, in terms of the power and decision-making structures; and the need to redefine women as 'healthy' in contrast to dominant conceptions within medicine of women's health as 'abnormal' to men's 'normal' and the pathologisation of women's health, in particular the linking of psychiatry and gynaecology (Doyal 1983; Broom 1991).

The initial focus for action of the women's health movement concerned consciousness

raising, de-mystifying medical knowledge and making it available to women to enable them to understand how their bodies worked. One of the earliest and most successful examples of this was the Boston Women's Health Book Collective which in 1971 published *Our Bodies Ourselves*. The campaigns which developed in the US, UK and Australia, largely centred on women's biology and reproductive systems, such as contraception and abortion (Doyal 1983).

As the women's health movement developed, differences became apparent in the types of action in different countries. In the United States the movement became characterised by the development of alternative feminist health care provision largely in the form of 'free clinics', voluntary provision by and for women (Ruzek 1978). In 1975 the National Women's Health Network was established to campaign for improvements in health policy and practice in the United States and made significant inroads for the inclusion of women in biomedical research leading to the establishment of the Office of Research on Women's Health (ORWH) by the National Institutes of Health in 1990, and the development in 1991 of the Women's Health Initiative, a study of the three leading causes of death in American women (Narrigan *et al.* 1997). In Australia a similar system of feminist health centres working to promote a social model of health were established, but have been more closely integrated within the state system (Broom 1991). In March 1989 the National Women's Health Policy was launched by the Commonwealth Department of Community Services of Health based on a social model of health.

The women's health movement in Britain began in a similar way, with consciousness raising and the production of information to educate women about their bodies. However, whilst consciousness raising groups were established, no similar system of alternative feminist provision emerged (Doyal 1983). The main reasons suggested for this within the literature concern: the existence of the prior existence of the National Health Service, free for all at the point of use, against which alternative provision would be seen to be promoting private medicine; and a belief that such services would attract unequal use by predominantly middle class women. (Craddock and Reid, 1993; Doyal 1983). These reasons were further compounded by the threats of cutbacks to the NHS and welfare provision, which began under a Labour government in the late 1970s and exacerbated by

the free-market monetarist policies of the subsequent Conservative governments (Doyal 1983). As such the women's health movement in Britain transformed from focusing on women's reproductive health and women as health care consumers to also defending the NHS. This has been argued to have arisen as cutbacks were seen to have significant implications for women as the majority users of services; as employees; and as the people who would be required to care for those falling outside NHS provision (Doyal 1983). Examples of such campaigns in Glasgow include the Politics of Health Group and the Clydeside Women's Health Campaign which will be discussed in Chapter 4 on the case study.

In contrast to the United States and Australia, the women's health movement in Britain has no overarching body (Foster 1991). Some authors have questioned the ability of the women's health movement to create change whilst remaining outside the mainstream political and policy arenas (e.g. Doyal 1983). One of the key areas in which the ideas of the women's health movement have been attempted to be provided within the NHS is in the development of Well Woman Clinics. Well Woman Clinics have been established both within GP practices and community medicine services, and whilst some may be no more than re-named family planning clinics concerned with women's physical health and medically defined problems, others have attempted to put the principles of the women's health movement - that services should be non-hierarchical, holistic, based on sharing knowledge and acceptable and accessible to women - into practice (Foster 1991; Thornley, 1987). Research analysing the development and practice of these types of clinics or centres have highlighted a number of problems experienced in running them, such as the 'watering-down' of principles and tensions with medical personnel accepting non-hierarchical practice. However, these accounts invariably conclude that such innovations are worthwhile and require expansion in mainstream practice (Craddock and Reid 1993; Foster 1991).

A number of distinctions can be identified in the theoretical underpinnings of the women's health movement which relate to the differing perspectives within feminist theory more generally (Zimmerman 1987:462) and inform the types of action taken. At a basic level, five broad traditions within feminism can be identified: liberal, welfare, radical, Marxist or

socialist, and post-structuralist or post-modern feminisms (Watson 1999:3). Liberal feminism is associated with the politics of equal rights and calls for women's equal participation within the public arena. Differences between men and women are seen as being of little consequence and capable of being mediated through public policy reforms such as sex equality legislation. In contrast, within welfare feminism there is the explicit assumption of the 'natural' differences between men and women, that "*women's biology is their destiny and motherhood must be revered and protected*" (Watson 1999:3). The policy focus is thus not on equal participation but on facilitating women's roles as wives and mothers through such development as family allowances and maternity benefits. Radical feminist perspectives emerged in the 1970s with the central argument of patriarchy as a system of oppression through which men 'as a class' exploit women in both public and private spheres. The policy focus has been largely on specific examples of women's oppression such as issues of domestic violence and rape. Within radical feminism arguments are often presented of women's innate difference from men. Socialist feminism, which has been particularly influential in Britain, contains a dual emphasis on patriarchy and capitalism as the origin of women's oppression, and thus combines gender and class as the locus for discrimination and inequality.

The influence between each of these feminist perspectives can be found within the women's health movement, with authors variously emphasising women's difference from men in health experience and health needs and others focusing on inequality in terms of treatment and access. These debates have been added to in recent years by the critique of black feminists and within post-structural or post-modern feminism of the universalising and generalising tendency within much feminism which ignores crucial differences between women (Barrett and Phillips 1992). As such, much of feminist analysis became criticised for 'racism, ethnocentrism and heterosexism' whilst there has been an increasing interest issues of subjectivities, identities and sexual difference and the social construction of sex and gender (Watson 1999:5).

Thus, as can be seen, the women's health movement comprises of a number of diverging perspectives and has developed from a 'plumbing and politics' approach (Ruzek *et al.* 1997a: 3) focusing on women's reproductive health and challenging the biomedical

paradigm, to advocating the development of a social or holistic model of women's health encompassing an analysis of the social, cultural, economic and environmental influences on the production of health and ill-health in the context of women's everyday lives. The universalising tendency of the women's health movement has been challenged on a number of fronts with women arguing that the complexities and diversities within women's health should be acknowledged. However some authors have the potential negative effect of such relativism for social action:

as soon as women gained strength and power to fight oppression from the subject position of woman, then postmodernist theorists came along and deconstructed the notion of the subject. (Watson 1999:6)

As Ruzek *et al.* (1997c) note, whilst acknowledging diversities of women's experience has been an important development, emphasising the complexities and contradictions in women's health could act as a disincentive to collective action or be used as a justification for the status quo and as such the search for commonalities between women is an important concern:

Developing the ability to see diversity without losing sight of the common ground is a pressing issue for women's health activists and policy makers. (1997:610)

Several authors have commented on the tensions within feminism between advocating women's equality or women's difference. This issue has particular significance for the implementation of the Women's Health Policy as will be discussed in subsequent chapters. Some authors have advocated a useful response to this criticism, suggestion that it is not a question of either/or but both:

the antithesis itself hides the interdependence of the two terms, for equality does not preclude difference and difference does not preclude equality. (Scott 1990:138)

Much of the research available on women's health focuses on women as a group, as the 'marginalised' other. This focus has undoubtedly been precipitated by the need to address both the exclusion of women and their experiences from medical research and discussions on health, and the desire to reconceptualise women's health from focusing on women's biological difference to a broader examination of the relationship between the biological

and the social through exploring women's health in the context of their everyday lives (Doyal 1999). However there has been a growing recognition of the need to deconstruct such analyses, to acknowledge the differences between women, but also to distinguish between the influence of biological sex and socially constructed gender roles, and of the relationship between the biological and the social in the production of health and ill-health (Doyal 1999).

'Gender' as a tool for analysis is conceptualised in different ways within the literature. Doyal (1999) notes a shift within feminist debates from a 'women' to a 'gender' approach, involving, "*an exploration of the dynamics of relations between men and women*" (1999:31) with gender roles largely ascribed to the biological sex. In contrast Annandale and Hunt (1990), highlighting that gender is often conflated with biological sex within much research, use an analysis of masculine and feminine 'gender role orientation' which cross-cuts the dichotomy of male/female to consider the associations with positive health, social roles and social status. Such analyses relate closely to the developing ideas within post-structuralist or post-modern feminism of the diversity of experience between women, and of the existence of a range of 'masculinities' and 'femininities'. Undoubtedly gender stereotypes, and the differences in status accorded to gender roles, impact strongly along sex lines. However, despite the fact that women are still the main care givers within society, an analysis of gender roles separate from biological sex may be argued to form the basis of a more transformative analysis, in highlighting their status as social constructs rather than natural entities. Such an approach is arguably increasingly relevant given the changing patterns of female employment and male unemployment and the potential impact this has on gender and social roles, and thus the production of health and illness. Such an analysis also arguably forms the locus for change.

Several authors have commented on the significant improvements that have been made in relation to research on women's health, such as women's greater inclusion in biomedical research (Narrigan *et al.* 1997; Ruzek *et al.* 1997b), and of a growing recognition of the differences between men and women in health care planning (Doyal 1998). However it is argued that crafting the 'psycho-social' onto the biomedical model (Ruzek *et al.* 1997c) and making services more 'women-friendly' are not enough (Broom 1991). The level of

progress that has been made in relation to women's health in bio-medicine as opposed to a broader vision of women's health can be argued to stem from the fact that such developments are "*fairly safe and minimally threatening to consider*" which "*skirts around uncomfortable issues about how health is socially, politically and economically produced... or how it may be produced if we were to envision it differently*" (Ruzek *et al.* 1997b:6). As such some authors have stated the need for the clearer articulation of a social model of women's health and the development of a new epidemiology of women's health (Ruzek *et al.* 1997c) or a feminist-socialist epidemiology (Doyal 1983) as crucial bases for creating change.

In summary, the women's health movement developed in response to the recognition of the inadequacies of the biomedical model and its detrimental impact on women's health. The focus of the movement has developed from a primary focus on women's biology to the advocacy for a social model of health and an understanding of women's health in the context of their everyday lives. The developments in relation to action on women's health in Glasgow are reviewed in Chapter 4. Of particular interest is how the WHP relates to the development of ideas within the women's health movement, and the negotiation of the central concepts of women, gender, equality and difference.

2.4 Policy Implementation

The primary focus of this research concerns the processes associated with the implementation of the WHP. As such the literature on policy development and implementation, and feminist critiques of these, are briefly reviewed to provide a context to this particular case.

2.4.1 Models of policy making

Rational-comprehensive models of the policy making process, such as developed by Simon (1957), present normative or 'ideal type' prescriptions which assume that human action can approximate pure rationality. Such models involve the "*selection of means which are conducive to the achievement of previously specified ends*" (Sanderson 1990:4). Simon

(1957) identified five key activities involved in rational decision-making:

- intelligence gathering
- identify all the options
- assessing the consequences of all the options
- relating the consequences of the options to the values of the decision-maker
- choosing the preferred option.

Rational-comprehensive models have received considerable criticism centring on the impossibility of achieving such conditions in practice. For example Dror (1968) has criticised such models as being too narrow, assuming perfect knowledge and perfect conditions, and neglecting any analysis of the constraints, such as time and resources, which commonly interfere in the process of policy-making. Such models have also been criticised as being “insufficiently dynamic” for failing to incorporate any consideration of the range of “possible futures” which may be affected by external and unpredictable events (Hogwood and Gunn 1984). Additionally, questions have been raised regarding the presumed ability of having rational objective decisions, and that such approaches neglect to consider competing values and interests. Finally criticisms have been levied at the artificiality of the separation of means and ends within such models.

Lindblom (1959, 1979) has been the principle theorist of the incremental approach, which he initially labelled ‘Successive Limited Comparisons’ (1959), and described as involving a ‘branch method’ of incremental change as opposed to the ‘root method’ of the rational-comprehensive approach. Central to Lindblom’s approach is the perception that no analysis can ever be complete given the complexity of phenomena. Thus rather than attempting the ‘unproductive ideal’ of synopsis he suggests that in accepting the limitations of analysis the choice becomes one of ‘deliberate designed incompleteness’, of the incremental model, rather than the ‘ill-considered, accidental’ incompleteness of the rational model.

Lindblom’s model offers a description, rather than a prescription of policy-making, which he argues takes place through a process of ‘partisan mutual adjustment’ (1979), involving small adjustments to perceived problems on the basis of bargaining, negotiation and

compromise of a broad range of actors and interests. He distinguishes three levels of incremental analysis: 'simple incremental analysis', where the analysis of alternative policies is limited to those that are only incrementally different from the status quo; 'disjointed incrementalism', which involves '*analysis marked by a supporting set of simplifying and focusing stratagems*' (1979:517); and 'strategic analysis', where '*analysis is limited to any calculated or thoughtfully chosen set of stratagems to simplify complex policy problems that is to short-cut the conventionally comprehensive scientific analysis*' (1979:518).

The incrementalist approach has been much criticised as a conservative approach. It defends the status quo; focuses on short term change which reinforces inertia; and that favours the interests of the most powerful and under-represents the unprivileged or politically disorganised (Smith and May 1980).

Modifications of each of these broad approaches seek to combine prescription and description. Lindblom's later formulation of 'strategic analysis' bears broad similarities to Simon's concept of 'bounded rationality', and represents a search for the 'middle ground' between the ideal-type rational model and the conservative 'laissez faire' nature of incrementalism. This is similarly reflected in the search for 'middle way' approaches such as Dror's (1968) 'normative optimal model', Etzioni's (1967) 'mixed scanning model' and Hogwood and Gunn's (1984) 'mixed framework', which seek to combine prescription with description and an acceptance that the most appropriate strategy will vary according to the issue at hand.

2.4.2 Policy Implementation

Models of policy implementation can be broadly categorised as comprising of two main approaches: 'top-down', and 'bottom-up'. The 'top-down' approach views policy development and implementation as discrete phases, and stress the necessity for policy makers to have control over those responsible for implementation, and the need for an absence of ambiguity and compromise in the decision-making process (Ham and Hill 1993). In contrast, 'bottom-up' approaches highlight the 'policy/action continuum' (Barrett and Fudge 1981) of the interaction and negotiations between those wishing to put

the policy into effect and those on whom the outcome depends.

Hjern *et al.* (1978) have developed such an approach using a 'network technique' which begins by identifying a networks of actors in an area relating to a policy or service, and asking their goals, strategies, activities and contacts, starting with street-level bureaucrats and moving up to the policy makers. They developed the 'implementation structure approach' (Hjern and Porter 1981) and describe the process thus: "*an analysis of the objectives of a programme suggest an administrative imperative. This imperative points to a potential pool of organisations, from which the implementation structure is formed*" (1981/1993:260). 'Implementation structure' refers not to organisations but 'the units of purposive action' which implement policies or programmes (Hjern and Porter 1981).

From their analyses of 'implementation structures' they highlight a number of common areas: that actors or organisations have a variety of goals and motives; that a programme rationale is developed in which 'purposive action' takes place; that authority relationships are based on professional status, coordinative competence, potential or real power and resource control rather than traditional authority structures; and that there exists a large degree of local discretion (1981/1993: 260). They also note that structures differ in their degree of cohesiveness: some being 'highly developed and regular' networks with established expectations or roles and actions; whilst others are 'undeveloped and ad hoc' where expectations have not been agreed and "*patterns of mutually beneficial interaction are poorly understood or have not been negotiated*" (1981/1993:261).

Merits of this approach have been argued to include a greater understanding of the process involved in implementation, and the ability to assess the relative importance of policies through actors' perceptions of problems and the strategies developed to deal with them. In addition, as the focus of such analyses is not on the attainment of established policy goals, the analysis extends to include the unintended consequences of policy decisions or programmes (Sabatier 1986). However, Sabatier has also raised a number of limitations of the method, suggesting that such approaches may be at risk of overemphasising the ability of actors to subvert the central policy aims through neglecting attention to the indirect control operated by the centre over the organisations. He also criticises the reliance of the

approach on the perceptions and activities of the actors, rather than having an explicit theory of the factors affecting the subject. He therefore argues that such analyses are unlikely to identify indirect factors affecting behaviour and those not recognised by the actors.

As with the rationalist and incrementalist models, differences between bottom up and top down approaches stem essentially from their desire to do different things. Whilst 'top-downers' are concerned with analysing the effectiveness of a policy and the ability of policy-makers to control the action of implementers, 'bottom-uppers' are concerned with "*mapping the strategies of actors concerned with a policy problem*" (Sabatier 1986/1993:280). Thus the primary concern is not with the extent of implementation but understanding 'actor interaction' in a policy area.

The 'implementation structure approach' of Hjern and Porter (1981) also highlights the significance of interests and power differentials in the implementation process, in contrast to the presumed rationality and objectivity of top-down models. Such concerns have similarly been raised within feminist critiques of the 'policy process' literature.

2.4.3 Feminist Critiques of the Policy Process Literature

In reviewing the mainstream literature of the policy process, the lack of acknowledgement of gender as an issue for analysis is clearly evident. Indeed one of the central features of feminist critiques of the literature has been in demonstrating the 'andocentrism' both in models of policy making and substantive policy studies, in theories, methodologies and findings (Hawkesworth 1994:105).

In relation to models of the policy process, a key area of criticism within feminist analyses concerns the concepts of rationality and objectivity. For example, far from the notion of a rational actor as being value-free, feminist authors have argued that such a concept incorporates gender bias and is often based on the idea of a single, male actor. As Hawkesworth (1994) notes, feminist critiques have routinely revealed andocentrism within traditional policy approaches which undermine their claims to produce objective accounts. Such concepts of objectivity as presented in the literature, as Hawkesworth notes are

'premised upon self-purging of bias and intersubjective agreement' and 'the conviction that the central problem of objectivity lies in the emotional and perceptual quirks of the observer impair the apprehension of external phenomena [which] mask the role of social values in cognition.' (1994:110). The impact of social values on perception is ignored within traditional accounts of the policy process. In contrast feminist authors have argued that the exploration of the role of social values affords the possibility of increasing objectivity. As Hawkesworth notes,

by fostering critical examination of the role of social values in framing research questions, demarcating credible evidence, and structuring modes of argument, feminist scholarship offers traditional disciplines a means to increase sensitivity to error and to purge androcentrism from disciplinary paradigms. (1994:110)

In addition to critiquing traditional approaches to policy analysis a number of feminists have developed alternative approaches to policy analysis utilising a variety of theoretical approaches such as social constructionism and discourse analysis which enable exploration of difference. One such approach, developed by Bacchi (1999) has been particularly insightful and is discussed next.

2.4.4 Bacchi - What's the Problem (represented to be)?

Bacchi (1999) develops an alternative approach to policy analysis within her "What's the Problem (represented to be)?" framework. For Bacchi, the starting point of policy analysis should be the analysis of 'problem representation', the explicit or implicit diagnosis of the problem which form the basis of the policy proposal. From a social constructionist perspective she rejects the idea of objectively identifiable 'problems'. Rather, she argues, whilst there exists in reality a range of issues that can be seen as 'objectionable', they only become problems when they are defined as such. Representations involve interpretations, which contain values, judgements and choices. She notes,

While there are a multitude of disturbing social conditions, once they are given the shape of an interpretation, once they are characterised as a 'problem' or a 'social problem' they are no longer 'real', they are interpretations or constructs of the 'real'. (1999:9)

For Bacchi the analysis of interpretations or representations are of importance as they form

the basis of ensuing interventions in policy recommendations; that is, the construction of the 'problem representation' limits what is seen as "*possible and desirable or impossible and undesirable*" (1999:4). She identifies five key questions to be asked in analysing problem representations in policies:

- *Is the problem (domestic violence, abortion etc.) represented to be either in a specific policy debate or in a specific policy proposal?*
- *What presuppositions or assumptions underlie this representation?*
- *What effects are produced by this representation? How are the subjects connected with it? What is likely to change? What is likely to stay the same? Who is likely to benefit from this representation?*
- *What is left unproblematic in this representation?*
- *How would 'responses' differ if the 'problem' were thought about or represented differently? (1999: 12-13)*

Bacchi draws attention to the work of particular authors, such as Dery (1984), who have highlighted the social construction of social problems. However, Bacchi contrasts her analysis to the 'pragmatic and interventionist' approach of incrementalism which premise the search for policy solutions to policy problems. Dery (1984), for example stresses the 'applied' nature of the incrementalist approach "*concerned with the production of administratively workable and politically realistic ideas for solving problems*" (1984:38). Broader social problems become 'pseudo problems' which should be avoided, for as Bacchi notes,

for political rationalists the 'ground rules for justifying or rejecting a certain [problem] definition' are that 'problems' must be defined so as to guide further policies. If they don't do this problem definitions are considered inadequate"
(1999:28)

Bacchi, in her approach rejects such pragmatism, which she argues 'constrains vision' by neglecting to examine issues they believe unresolvable. In contrast, central to the 'What's the Problem?' approach is understanding "*the processes by which problem representation impose constraints on social vision*" (1999:29) and highlighting what is left out in the development of problem representation.

Bacchi places importance on the need to recognise and explore the inter-connections between problem representations in different policy areas in addition to what remains unaddressed in the way certain problems are represented. She highlights two levels of

problem representation which require analysis: the representations of what is a 'concern' and the competing interpretations of the 'causes' of that problem (1999:4) Emphasis is placed on the need to acknowledge competing interpretations, including both those arguing for and rejecting the notion of problem status. She also stresses that the presuppositions contained within 'problem representations' are not necessarily held by those making the representation; that particular representations may have been selected for 'instrumental' reasons, for the achievement of a particular goal (1999:9-10).

Bacchi uses this approach to analyse the way in which 'women's inequality' has been constructed as a social problem. She challenges the assumption that gaining 'problem status' represents a success in itself or a commitment to change. Indeed she criticises the assumption that having women's inequality on the agenda is a 'good thing', and the reluctance of some feminists to examine the representation of the problem in the light of the evident lack of change. In contrast, she argues, through a 'What's the problem?' approach that 'women's' inequality has not gained a place of importance in policy-making, nor has the equal opportunity legislation developed been designed to reduce that inequality (1999:8).

Whilst Bacchi argues that constructionism is the 'natural home of feminism', not all feminists are in agreement with the value of this approach. For example, in the same vein as the dilemma of emphasising diversity amongst women highlighted within the women's health movement, some feminists are concerned about the impact of such relativism undermining the legitimacy of political campaigning for women as a group, stressing the need to highlight commonalities rather than differences. In addition, the focus on interpretations is seen to include only those articulated, ignoring those unexpressed. Bacchi suggests that her approach avoids such concerns by including in the analysis exploration of what is left out of problem representations, and by aligning herself to 'social' or 'material' postmodernism:

It resurrects the social and structural by drawing attention to the relationship between discursive and non-discursive factors... it describes discourses as practices and insists that we attend to their material effects. It emphasises the limits placed on constructions by structural factors, including the power of institutions and individuals to shape discourse, whilst insisting upon the possibility of challenging constructions which have effects we despise... it does this through

an insistence upon the need to attend to the implications of problem representations. In this view... 'pseudo problems' become the stuff of policy analysis (1999:64)

Bacchi's framework has been retrospectively informative of the approach taken to analysing the implementation of the Women's Health Policy in this thesis. A central part of this concerns the representations of women's health as a basis for understanding the directions taken in trying to translate the policy into action. In addition efforts have been made to 'unpack' the Women's Health Policy to analyse the implications of the representation of the problem on its implementation.

2.4.5 Summary

This section has highlighted some of the key debates surrounding policy development and implementation, which will be considered in analysing the processes associated with the implementation of the WHP in later chapters of this thesis. Of particular interest are the feminist critiques of traditional approaches, in highlighting the myth of androcentricity and the importance of social values in both policy formulation and implementation. These issues are further explored in the next section of this review, exploring approaches to gender inclusion.

2.5 Approaches to gender inclusion within organisations

As has previously been highlighted, no literature relating to the implementation of social/holistic models of women's health within organisation has been identified. However, there exists comparable literature on strategies for 'gender inclusion' within organisations, particularly relating to equality or equal opportunities policies.

There has been a long debate within the literature on sex equality within organisations, primarily focusing on employment and personnel issues. Issues debated include: whether the objective should be equality of opportunity or equality of outcome; whether the goal is a recognition of women's difference, or the removal of gender inequality; and whether the goal is equality in terms of 'sameness' or in terms of parity with men. As Cockburn (1991) has noted, these debates reflect the different schools of feminism which have all been

central to campaigns for equal opportunities. Debates over gender difference and sameness are still unresolved within feminism, and the divide is often used as a counter to change within organisations, the argument being that women can be different or equal but cannot be both. (1991:161).

One key issue discussed within the literature is the role of the state in relation to the development of women's equality. Several authors have commented on the dilemma facing feminists of trying to pursue equality policies within organisational and political structures and systems which are regarded as highly gendered and which reinforce women's inequality (Cockburn 1991; Halford 1992; Hawkesworth 1994). As Rees (1999) notes such structures and systems are based on a particular form of 'gender contract' of male breadwinner and female home-maker, failing to acknowledge the diverse and changing family structures. In addition, as Halford (1992) notes, a distinction between 'public' and 'private' spheres is commonly used to justify the state/organisation's lack of involvement in the 'private' sphere. However, in a similar vein to feminist campaigns of the 'personal as political', feminists reject that such a distinction can be made, highlighting how the 'private' is shaped by the 'public', for example in the lack of action by the state/organisations on issues such as childcare (Halford 1992).

Feminists differ in their views of the state and the potential to create change. Whilst liberal feminists see the state as the "*neutral arbiter of conflicts in society*" (Halford 1992:108), and thus the potential for change with legislation and women's initiatives, Marxist/socialist and radical feminists see the role of the state as seeking the preservation of capitalism and/or patriarchy. (Halford 1992). As such authors differ as to whether they see the best approach to working towards women's equality to be working within or outside the system. As Broom (1991) notes in her analysis of the women's health movement in Australia, the strategy for many includes a combination of both. Whilst working with the system can lead to the institutionalisation and 'watering-down' of feminist principles (Broom 1991) there is also the recognition that many of the 'goals' of feminism can only be achieved within the state and organisations (Halford 1992). The remainder of this section will focus on approaches to women's equality within the state and its organisations.

Following Rees (1999), three main strategies can be identified aiming to promote equality within organisations: equal treatment; positive or affirmative action; and 'mainstreaming'. These are now discussed in turn.

2.5.1 Equal Treatment

Equal treatment was one of the first strategies developed to promote gender equality within organisations. Such approaches reflect liberal feminist perspectives and are based on the premise that men and women should be treated the same (Rees 1999). This approach formed the basis of many campaigns and led to the development of legislation such as the Equal Pay Act (1970) and the Sex Discrimination Act (1975), which sought to address incidences of direct, and later indirect, discrimination. Problems experienced in utilising the Equal Pay Act due to the gender segregated labour market, making it difficult to establish equal pay claims with men, led to the development of Equal Pay for Equal Value amendment to the Act in 1986. Again difficulties were experienced in utilising this law, in part, as Cockburn (1983) notes because the 'gendering' of work affects its valuation (Rees 1999)

Several criticisms have been made of the equal treatment approach. Firstly the approach is seen as individualised, in that its operation is dependent on individual claimants proving discrimination rather than addressing the structural basis of that discrimination. Secondly equal treatment has been argued by some to have led to 'rough justice' in some instances such as pension rights due to a failure to acknowledge the differences between men and many women's participation in the labour market over the life-cycle (Rees 1999). In addition, such reforms are confined to the workplace, retaining the public/private distinction and rendering the work performed largely by women in the family invisible to law (Bacchi 1999:96). The recognition that equal treatment did not necessarily lead to an equality of outcome provided the impetus for the development of a new approach - positive or affirmative action (Rees 1999).

2.5.2 Positive/Affirmative Action

According to Rees (1999) positive action

recognises the differences between men and women and seeks to create opportunities for women who have missed out in some way because of their gender. (1999:170)

Examples included the development of women-only training courses; and 'family-friendly' measures such as childcare, flexible hours, career breaks, part-time working and job-sharing (Rees 1999). In addition examples of 'positive discrimination' or affirmative action include the establishment of 'quotas' for the numbers of members of 'disadvantaged' groups to be represented, giving priority in areas where they are under-represented (Rees 1999). Positive discrimination approaches in the US and Canada have been established following similar action against race discrimination, although they are increasingly being challenged, whilst such action has been made illegal in the UK (Rees 1999:171).

Limits to this approach, as with equal treatment approaches, include the failure to challenge the 'gender contract', reinforcing the link between women and domestic responsibilities in seeking to support this role (Rees 1999). In practice initiatives such as training have been precariously funded, and invariably failed to be included within the mainstream of the organisation even after their proven success (Rees 1999). In addition such approaches incorporate a '*deficit model*' of women (Rees 1999:172), and connotations of 'special treatment' and 'privilege' has led to them often being resisted by the groups they were intended to help. As Bacchi (1999) notes

A number of women and members of other targeted groups oppose affirmative action because they dislike the implication that affirmative action recipients are 'less qualified' than those they replace, and that they have been 'assisted' to surmount 'their' 'disadvantages'. (1999:109)

Both equal treatment and positive action are approaches which incorporate the aim of removing difference between groups in organisations. Such approaches as Cockburn (1991) notes, exact "*'norm' alisation and assimilation of other categories as the price of acceptance: you may find a place as long as you simulate the norm and hide your difference*" (1991:219). This contrasts with the 'mainstreaming' approach to equality.

2.5.3 'Mainstreaming'

According to Rees (1999) mainstreaming involves the recognition of differences between men and women, and among women, and the gendered nature of existing organisational structures. She argues the approach is rooted in postmodernism, in which diversity and difference are valued and accommodated rather than assimilated. Mainstreaming involves,

integrating equality into all policies, programmes and actions from the earliest stages of their formulation to their implementation and review... building the equality dimension into all policy-making even where, on the face of it, the issue may not seem to be relevant... [it] represents a paradigm shift in conceptualising equality within the context of both employment and service and product delivery (1999:165-66)

Support for the approach has been growing, being backed by the UN 4th World Conference on Women in Beijing in 1995. Since 1996 the EU has recommended the mainstreaming of equality in all EU policies, programmes and actions, and further supported this in the Treaty of Amsterdam in 1997. In the UK the Equal Opportunities Commission has adopted mainstreaming as its long term aim since the mid-1990s, and has been involved in advising government departments (Rees 1999). Such developments have occurred since the period of analysis in this thesis, but mainstreaming of women's health has now also been developed within the WHO documents, for example "Gender and Health: Technical Paper" (WHO 1998).

The approach has raised a number of concerns amongst feminists: firstly the threat of mainstreaming for the existence of special equality units and officers which have taken so long to establish; and secondly the fear that equality becoming the responsibility of all will in effect lead to it being the responsibility of none (Rees 1999). Rees suggests, however, that special programmes, legislation and positive action, far from being threatened or removed, will be essential to the "*secure underpinning*" of the approach (1999:166).

'Mainstreaming' as an approach is still at an early stage of development and little evidence of its actual operation is available. However that the approach is supported, particularly at the European level, arguably provides a large 'carrot' for its implementation, in theory at least. As Rees (1999:174) notes, all member states depend on the EU for finance, and in the future all applications for funding must demonstrate the mainstreaming of equality

within their projects. The problem lies, however, in ensuring such commitments are operationalised. Having reviewed the various types of gender-based policies, we now turn to an examination of their implementation within organisations.

2.5.4 Implementing women's/equality policies

A variety of research evidence exists which has examined attempts to implement a range of gender-based policies within organisations (Cockburn, 1991; Halford, 1992; Stone, 1988; Itzin 1995b; Thobani, 1995). In discussing the factors influencing the implementation of such policies and initiatives, these studies have invariably drawn out those factors presenting obstacles. At root these concern two inter-related factors: organisational structures and organisational cultures.

Traditional approaches to the study of organisations are noticeable for their lack of attention to the gendered nature of organisations. Studies of organisational forms and structures are often based on the assumption of gender neutrality, and whilst the once neglected study of organisational culture has increased in recent years, gender dynamics often remain unexplored, with culture being discussed in the context of the male norm, and male power and authority unquestioned (Collinson and Hearn 1996). A key concern of feminist authors on organisations has been to expose the gendered nature of organisations and cultures, and indeed the relationship between organisational structures and cultures. Such accounts vary according to differing feminist perspectives.

2.5.4.1 Organisational Structures

Critiques of models of 'bureaucracy' as the dominant form of organisation in modern capitalist societies form the basis of much of the literature on organisations, in particular the appropriateness of the model developed by Weber (1968) as an account of the operation of organisations. As Halford (1992) notes, Weber presented his model as an 'ideal type' of characteristics to be found in bureaucratic organisations, emphasising the following features:

- *a specialised division of labour*
- *a hierarchy of authority with a clearly demarcated system of command and responsibilities*

- *a formal set of rules and procedures governing operations and activities co-ordinating behaviour in a predictable, uniform and impersonal manner*
- *a body of full-time permanent officials, appointed according to technical competence, trained in specialised tasks, paid according to rank in the hierarchy and who may develop careers based on their ability and seniority* (Halford 1992:162)

For Weber, bureaucracy was seen as the most rational and efficient form of organisation, in contrast to more traditional systems of organisation and authority such as through nepotism and corruption (Morgan 1996). Emphasis is placed on the establishment of formal structures, formal rules through which authority is maintained. However, feminists have challenged the construct of 'rationality' within models of bureaucracy as being free of values and interests, and the artificial distinction made between public and private spheres. Rather, gender relations and gender interests are seen as being deeply embedded in organisational structures and practice. In addition to the formal structures identified by Weber (1968), feminists draw attention to the existence of a range of informal structures within all organisations through which organisational goals are developed, challenged and changed. Informal structures develop due to the inability of organisations to establish a complete set of rules to guide behaviour and to control behaviour (Halford 1992), and it is within these informal structures that decisions made are shaped by the cultural context of shared meanings and norms within patriarchal society. In addition, some authors emphasise that the institutionalisation of male dominance within organisations does not merely reflect gender relations existing 'outside' in wider society, but that gender relations are articulated, and reproduced within organisations (Halford 1992; Itzin 1995a)

The value accorded to 'bureaucracy' as a model for organisations and arguments as to the intrinsic or otherwise relationship of bureaucracies with capitalism and patriarchy varies with differing feminist perspectives. For example liberal feminists tend to accept the model of bureaucracy as neutral, and see gender inequality as resulting from sex-segregation and sex-stereotyping within organisations. As such the solution lies in improving access of women to senior positions within the organisations, as developed in the 'women in management' literature (Newman 1995b). In contrast radical feminists such as Ferguson (1984) see bureaucracies as inherently patriarchal, and taking a separatist approach, stress the need for women to develop alternative organisations and practices. Socialist feminists in a similar way highlight the production and reproduction of capitalism

and patriarchy within bureaucracies as inherent and systemic, supported through the separation of public and private spheres and the sexual division of labour. There is a limited presentation of alternatives, short of a revolution, and such accounts premise the need to change the macro-structural context (Cockburn 1991).

Whilst liberal and radical feminists' accounts incorporate a binary opposition between women and men, socialist feminists expand on this dichotomy to include dimensions such as race and class, and post-structuralist accounts highlight the differences between women. In post-structuralist accounts of bureaucracy, organisations are not seen as inherently patriarchal, nor as unified structures, but sites of 'discursive formations' (Pringle and Watson 1989), in which competing interests are continually constructed and reproduced. From this perspective, the view of organisations as representing 'male' interests results from the ability of 'men' to impose their interests, but such dominance is neither fixed or stable. A strategy of change is seen as increasing the number of "*women working as feminists within male dominated bureaucratic structures*" (Witz and Savage 1992:39), as exemplified in the 'femocrat strategy' of women engaging with the Australian state (Pringle and Watson 1989).

In a similar way, some authors have argued that bureaucracy is neither inherently capitalist or patriarchal, but that its present materialisation results from the dominance of both as structural pressures which are interpreted and reproduced in organisations by and through specific cultures. For example Ramsay and Parker (1992), in seeking to demonstrate the power of both 'macro' structure and 'micro' agency, have argued that Weber's model can be seen as a particular 'formulation of the problems' that needs to be negotiated by all organisations rather than ready made solutions that all organisations can adopt. They present an alternative ideal type of a 'neo-bureaucracy' which they describe as the middle ground between bureaucracy and anti-bureaucracy - having no structures or rules - which they see existing in practice in feminist and workers co-operatives. The 'neo-bureaucracy' accepts the 'functional imperative' of bureaucracy in terms of the benefits accrued socially through organised labour without accepting the capitalist/patriarchal definition of the solution (Ramsay and Parker 1992).

Despite the varying focuses of differing feminist perspectives, these perspectives share a common focus on the need to address the sex-segregation of women within organisations. According to Hawkesworth,

theories of bureaucracy incorporate gender norms that are replicated in a sex-segregated occupational structure within bureaucracies and in sex-stereotyped interactions of bureaucrats with client groups. (1994:107)

Several authors highlight the impact of labour market segregation (Cockburn 1991; Itzin 1995a; Rees 1999). Women's labour is characterised as being segregated horizontally, in terms of working in different industries, and professions, for example those which mirror women's caring gender role, such as social work, nursing and primary teaching, in contrast to men's dominance in planning, finance and engineering. Labour segregation also exists vertically, with women typically occupying lower status position within those sectors. For example, despite the relatively smaller numbers of men within the caring professions they tend to be proportionately over represented in senior positions. Some authors have highlighted that as professions such as personnel, traditionally seen as 'soft' area within organisations, have increased in strategic importance as 'human resource management', so they have come to be dominated by men and correspondingly increased in status (Newman 1995b). Increasingly a further form of segregation within the labour market is 'contract segregation', with women occupying those areas of the labour market, typically characterised as flexible, casual labour, with short-term or no contracts and limited access to training and career progression (Rees 1999).

As Rees (1999) notes theoretical explanations of the segregated labour market generally focus on the relationship between capitalism and patriarchy, sex-role stereotyping and a variety of 'exclusionary' tactics employed by men, such as through trade unions (Cockburn 1983). As such sex segregation can be viewed as mediated and reinforced through organisational cultures.

2.5.4.2 Organisational Culture

Organisational culture refers to "*shared symbols, languages and practices... and deeply embedded beliefs and values*" (Newman 1995a:11). As with organisational structures, much of the traditional literature on organisational culture has failed to analyse culture as

gendered. As Collinson and Hearn (1996) note, there is little questioning within the literature of the dominance of men and managers; rather there appears to be a “*embedded and taken for granted association, even conflation, of men with organisational power authority and prestige*” (1996:1). In particular the literature fails to question the nature and images of middle and senior management which is ‘imbued’ with particular notions of masculinity. Itzin (1995a) argues that the gender culture is often unarticulated as it is taken for granted as ‘natural’. Cockburn (1991) argues that men have become ‘disembodied’ as ‘invisible men’ as the dominant masculine discourse appears to speak universally for everybody. As such, she argues that a key element required if all ‘voices’ are to be heard with equal status and validity is to “*bring men back to their bodies*” (1991:239) in order to specify the dominant discourse as ‘male’.

Much of the feminist literature highlights the interrelationship of structures and cultures within organisations. As Halford notes

The historical form of the organisations, the people who work in them and the political structure, too, cannot be separated from the social relations of gender (and those of class, and race and sexuality) which exist in society more generally. But what happens in state organisations is not simply a reflection of what happens outside. The scope of activities which local state institutions are involved in, for example education, planning and design and health, means that policies and practices also shape gender relations. (1992:183- author's emphasis)

Also central to the arguments of feminist authors is that culture is not fixed but capable of being changed (Halford 1992). Newman (1995a) identifies three different cultural forms to be found in statutory sector organisations: traditional, competitive and ‘transformational’, each demonstrating differing representations of gender and appropriate gender roles. Each are ‘ideal types’, oversimplified, and may be seen as existing separately or simultaneously within organisations. ‘Traditional’ cultures, are characterised as those of ‘old’ public sector bureaucracies, based on a mixture of managerial and professional regimes, with a hierarchical structure and horizontal and vertical segregation of labour reflecting traditional notions of appropriate gender roles. The culture of such organisations is paternalistic and women’s gender roles have a ‘quasi-familial’ status, being perceived variously as mothers, aunts, sisters and daughters, with the occasional tomboy. For Newman (1995a) such gender roles contain ‘invisible hierarchies’ between men and women and male and female

roles. Women outside the appropriate gender roles are labelled as 'troublesome' and 'difficult'.

In contrast, within 'competitive cultures' which are developing in the public sector with the introduction of the private sector 'business ethos' with internal and external competition, gender roles have become less familial and more overtly sexualised. Newman notes that images of 'hard', 'macho' and 'cowboy' styles of working are prevalent. As traditional hierarchies are dismantled, power is increasingly based within informal structures controlled by men, which women are permitted to join if they can prove themselves 'tough enough'. As Newman notes, there is 'notional equivalence' for men and women, but one which contains a contradiction for women: succeeding in such an environment requires acting in ways characterised to be 'unfeminine' and thus attracting contempt from men. This situation is further complicated by the persistence of 'traditional' cultures simultaneously. Newman notes,

To succeed you have to join the competitive ethos, but you have to retain your womanly characteristics and remain 'nice' while doing so. But the competitive culture is not a place where 'nice' women thrive (1995a:18)

Newman's third cultural form, 'transformational', refers to the 'new managerialist ethos' gaining currency in the public sector. As Newman notes, this approach is often seen as opening up possibilities for qualitative change within organisations and increasing women's equality. Within this culture emphasis is based on building long-term strength of the organisation, valuing people rather than short term competitive success. 'Soft' skills of communication and working in partnership are seen as central within this cultural type, with women respected as 'people' rather than being accorded gender roles. However, Newman notes a number of possible drawbacks to this approach, such as the emphasis on consensus leading to 'gender blindness' and undermining claims of difference and arguments of inequalities which are seen as 'diversions'; and that organisations, whilst seeking to develop new 'women-friendly' ways of operating, fail to challenge existing "(male) power bases in which the old ways of doing things are entrenched" (Newman 1995a:19). As such, Newman suggests, equality in this culture is 'illusory' and inequalities of power remain.

A common theme within the literature concerns the use of sexuality within organisations as a form of control over women (Cockburn 1991; Hearn and Parkin 1988; Itzin 1995a; Pringle 1988). Far from being rational and impersonal arenas, Cockburn (1991) argues that organisations routinely exploit women's and men's emotions and sexuality with a range of "*officially sanctioned and enforced gender behaviours*" (1991:218) and a heterosexual culture. Within this women are rewarded for staying in their proper place and penalised for straying into men's territory. She notes, "*they exert a masculine cultural hegemony that makes it unlikely that women will willingly forfeit men's approval, will identify with each other or feminism*" (1991:217).

Sexual harassment within the workplace is seen as a means of exerting that control, which some authors have argued is joined 'seamlessly' with the broader organisational culture. As Hearn and Parkin note

Male managers with female subordinates may use sexuality, harassment, joking and abuse as a routine means of maintaining authority. This may be thoroughly embedded in the taken-for-granted culture of the organisation. (1987:93)

In reviewing the literature on implementing 'gender inclusion' policies within organisations, a number of authors have highlighted a range of structural, cultural and operational barriers to the successful implementation of women's/equality policies within organisations. These include the structural isolation and lack of status of women's units; limited political support, departmentalism, organisational inertia, weak laws and the absence of monitoring, organised male interests and the male culture of organisations. Much of this literature refers to implementation of policies within single agencies.

Cockburn (1991) as a result of her research on attempts to introduce sex equality into four different organisational environments (retail, a government department, a local authority and a trade union), notes the limited success of equal opportunity and positive action measures. She notes that while senior managers were willing to adopt the 'short agenda' of removing bias in organisations in such areas as recruitment and promotion on ethical and practical grounds, they were less willing to accept the 'longer agenda' of furthering women's equality within organisations in addressing cultural barriers and according women's work equal worth and status. She argues that implementation was limited due to:

weak and ineffective legislation, no monitoring, no penalties attached to non-compliance, and a tendency for organisations to adopt high profile but cost-free measures (1991:215).

Cockburn notes that men's resistance to women's equality is logical. Women in seeking change are challenging structures, culture and patriarchal power relations which form the power base of men in organisations. She notes that men often resist change in ways not obvious to them as "*men are caught up in the compulsion of patriarchal relations as much as women are. Male power is not occasional, inadvertent or accidental. It is systemic*" (1991:220- emphasis as original). Halford (1992) similarly highlights resistance stemming from the explicit challenge in women's initiatives to the assumed rationality of organisations by exposing the gendered dimensions of organisations. In addition through rejecting the distinction between public and private they also challenge long-held assumptions about the areas of activities local authorities should be involved in.

Authors also highlighted organised male interests within organisations acting as an obstacle to change. Halford (1992) identified three levels: trade unions, professional groups and chief officers. Several authors have highlighted the importance of securing external support for women's policies, particularly from trade unions, but are in agreement that gaining that support has been particularly difficult in manual worker unions (Cockburn 1991; Halford 1992; Stone 1988), who could often use disruptive tactics to hinder policies (Halford 1992). Halford also notes that professional groups tend to be largely male and dominate the management of local authorities. These groups control entry into professions in terms of recruitment and regulate practice, which is also gendered. Finally the chief officers of an organisations, with overall responsibility for co-ordinating activity within organisations, are usually male and older, forming, Halford suggests, a "*bastion of organisational resistance*" (1992:178).

Stone (1988) in her study of local government equal opportunity initiatives highlighted a number of problems encountered stemming from a lack of clarity and decision-making as to the role and remit that the initiative or unit had been established to progress. Whilst Stone (1988) highlighted a consensus of opinion that there was a need for a separate forum of sufficiently high status where women's issues could be discussed, these were seen to be

limited by a lack of strategic thinking about how to access the decision-making structures through which policies could be implemented. Halford (1992) similarly notes that whilst women's initiatives, often established with non-hierarchical and participatory, non-bureaucratic, principles have operated successfully within initiatives, they have not achieved a similar success in challenging the broader structure of the organisations.

Political support and problems relating to community representation were also identified by Stone (1988) as barriers to the implementation of equality initiatives. Community participation, seen as central to enabling women's voices to be heard either through co-opted members or open access was similarly seen as problematic due to the inherent unrepresentativeness of members (a common problem in community participation) and raising the expectations of women through participation without the organisations being able to deliver on issues raised. Representing the diverse needs of women was also seen as a problem, with a common failure to address the needs of black and working-class women.

Halford (1992) highlighted the problems associated with the location of women's initiatives predominantly within central co-ordinating structures of the organisation, capable of devising and co-ordinating policies but having no remit or responsibility for implementation. As such the onus is on the departments to implement (1992:161). Halford (1992) highlighted two processes of resistance to change within organisations: 'empire building' and 'organisational inertia'. She defines 'empire building' as "*competition between departments*" (1992:164), for example over limited resources, or efforts to increase power, control and status as a means of career progression within hierarchical organisations. Such a process results in the 'insularity of departments' and a limited amount of co-operation and communication between them. Combined with this is the tendency of departments to be dominated by professions, so that local authorities "*remain in essence loose confederations of semi-autonomous empires*" (Smith 1966:29 cited in Halford 1992). As Halford (1992) notes the implementation of centrally-based women's policies are resisted by departments which object to what is seen as outside interference, and exacerbated by the lack of professional status of women's officers and the low bureaucratic status of equality units.

The second process of resistance identified by Halford 'bureaucratic inertia' where potential for change is restricted by the horizontal and vertical limits to information and knowledge in highly fragmented structures, which restricts the transparency of action, and the defensive response produced to change. Halford noted a tendency where uncertainty existed to claim action where none existed, such as in requests for 'gender comments' in committee reports (1992:169).

In summary, a number of authors have highlighted similar experiences of resistance to gender equality strategies relating to issues of structure, culture, power and agency. The relevance of these barriers will be explored in relation to the implementation of the WHP. However, several of the authors also make suggestions for the conditions they consider would be necessary to achieve a more successful implementation of such policies, which are discussed below.

2.5.5 Strategies for gender inclusion

A key issue arising within the literature concerns debates over which is the best approach to take to achieve change within organisations. Authors differ in their view as to whether the approach should be incremental, acting on a 'short agenda', or 'transformative' (Cockburn 1991) seeking inclusion of the 'long agenda' of feminist principles. These differences stem from the differing theoretical perspectives within feminism, and in practice tend to be a combination of both.

Several issues have been identified within the literature as important features required for the enablement or successful implementation of policies to promote gender equality or parity: adequate resources; power; leadership; grassroots action; opportunism; clear goals; identified projects; and changes to the macro context in terms of economic and social policy. A combination of most of these features are highlighted by authors based on the experiences of policies seeking to promote change in differing contexts.

Halford (1992:160) argues that the degree to which the implementation of a women's initiative within local authorities will be successful depends on a range of issues including the availability of resources, political commitment and leadership, and the level of

'political mobilisation' in a local area. In her study of a 'gender and organisational change' initiative, Itzin (1995b) describes the enablers encountered in the course of the project as including: key committed individuals, an approach of 'crafting strategy' (Mintzberg 1987) which is both planned and emergent, and presenting the arguments opportunistically in the context of whatever initiative could be of use, such as the Opportunity 2000 campaign (1995:142). Thobani (1995), in her discussion of the success of a local government equality initiative in Hounslow, highlights four key issues: access to power, in the form of the representation of the Unit at senior management level; the agency of the people directly involved in terms of commitment and resilience; the equal opportunities work of the Unit matching the strategic direction of the organisation; and resourced community-based innovative project development.

Andrew (1995) in her analysis of the development of the Women's Action Centre Against Violence in Ottawa, Canada, highlights a number of enablers to the development of the Centre: the involvement of the women's movement, the successful lobbying of the municipal government for the recognition of their responsibility in the prevention of violence against women and that only a feminist analysis of violence against women could produce an effective policy framework. Instrumental in this were the close involvement of a woman politician who organised a network of women and organisations which were held together by a clear goal and a definite project.

Cockburn (1991) in her study of men's resistance to sex equality in organisations concluded that whilst there was an acceptance by some senior men of the 'short agenda' of removing bias within organisations this was not matched by an acceptance of the 'longer agenda' of 'transformative change' advocated by feminists. She argued that an increase in parity within organisations required external changes in social policy, economic policy and a strengthening of the law in relation to equal opportunities legislation. In addition she suggested eight strategies required to increase 'feminist practice' in organisations:

- *need to get the equality initiative placed in a high and secure position*
- *commit energy and resources to building a women's movement within the organisation*
- *establish the legitimacy of a separate activity and a discourse of 'difference on our terms'*
- *develop practical alliances with supportive men*

- *transformative aims of the equality project should be conscious*
- *strategic approach to the role of the equality officer*
- *need to address the question of forming alliances between disadvantaged groups (1991:232-235).*

Freeman (1982) in her overview of feminist policy initiatives in the US concluded that there were two key features in feminist success in reshaping public policies: firstly the development of alliances between grass-roots feminist activists and national women's organisations; and secondly pursuing an 'anti-discriminatory strategy' linked to the civil rights agenda based on incremental change that was non-threatening to the organisations. Both Freeman (1982) and Cockburn (1991) have highlighted the limitation of policy successes to those aspects least challenging to the status quo, and as Freeman notes, do not challenge deeply embedded sexism, the structures of male privilege, or break "*the tradition that a women's obligations and opportunities are largely defined by her family circumstances*" (1982:63).

Rees (1999) in her discussion of the growing support of 'mainstreaming' policies in the EU and UK notes that there is little documentation of the policies in action, but suggests six aspects important to the operationalising of such policies:

- *recognising andocentricity*
- *gender disaggregation of statistics*
- *visioning*
- *participation and democracy*
- *awareness raising and training in mainstreaming*
- *monitoring and evaluation, processes and procedures.*

It should be noted that most of the authors discuss 'enablers' to the implementation process with a word of caution: all of the authors cited here stress that achieving any change is a hard won battle, limited and ongoing, as opposed to anything approximating a completed project. In summary, a variety of issues have been identified within the literature which relate to contrasting strategies for gender inclusion in organisations. These will be compared with issues emerging from the analysis of interview data relating to the WHP.

2.5.6 'Women' - homogenous or diverse?

A key concern within the literature concerns the conceptualisation of 'women'. A dilemma

persists within the literature between the representation of 'women' as a homogenised group, either presented as 'different' from 'men', and/or subject to inequalities in society as a sex, and the need to recognise the diversity of experiences amongst 'women' through other categories such as class, disability, race or sexuality. Whilst feminist analyses have been heralded on the whole as putting gender into the frame for analysis, much has similarly been criticised for failing to acknowledge that all women, and indeed all men, are not the same, or equally unequal or, in the case of men, privileged.

For example as Collinson and Hearn (1996) note, liberal feminist analyses as exemplified in the 'women in management' literature which focuses on the women's different methods of organising, managing and leading and on the need to develop women's skills to fit into the hierarchies rather than challenge them, risk being reductionist, essentialist and victim blaming, and neglect a critical examination of the hierarchically and gendered power of men as managers. In addition they argue that structuralist accounts caricature men's power and women's subordination and ignore the 'analytical significance' of the organisational practices through which these are constituted. Finally, whilst welcoming the post-structuralist feminist analyses of gendered power relation which incorporate both structure and agency, and highlight the diversity between 'men' and 'masculinities' and between 'women' and 'femininities', still Collinson and Hearn (1996) argue that there is limited analysis of men in positions of organisational power.

In a similar way Newman and Williams (1995) note that in accounts of women's marginalisation within organisations as resulting from female biology, and male discriminatory practices, issues of class and race remain 'invisible presences', as what is contained within the 'universal' category of 'women' is invariably white and middle class. The neglect of other social categories is seen to arise from the imposition of a 'man/woman frame' (Bacchi 1999) which does not reflect the complexity of identity or diversity of experience (Newman and Williams 1995). The use of 'category politics' has been identified by several authors as contributing to the development of 'hierarchies of inequality' in which different groups, women, ethnic minorities, disabled people etc., compete to be seen as the priority, and for scarce resources (Bacchi 1999; Cockburn 1991; Itzin 1995b; Stone 1988). Some authors highlight the dangers of embracing diversity in

terms of the shift from a 'radicalised agenda' to one of increasing individualism, reducing the collective power needed to secure change. As such some authors stress the importance of 'building alliances' with other 'disadvantaged' groups, and between women, highlighting commonalities rather than differences. As Newman and Williams (1995) note

What is necessary is the development of a concept of equality that can incorporate difference and diversity not just in an individualised sense, but in its collective sense – around a politics of difference that exists to assert identity and to challenge inequality and exclusivity (1995:122)

A suggested means of addressing this can be seen in approaches to analysing 'problem representation' within policy, as advocated by Bacchi (1999).

2.6 Multi-agency working

Much of what has been discussed so far has concerned policy implementation within single organisations. However, the implementation of a social model of health, due to its breadth, necessitates the co-ordination or collaboration of a range of spheres and organisations in order to address health holistically. Such an approach is seen as central to the WHP, and thus in this final section, the literature on multi-agency working is explored.

2.6.1 The policy context

Exhortations for multi-agency working within the public sector, and between the public, voluntary and community sectors have been increasingly common in recent years. Since the period of analysis the New Labour Government has introduced a number of policy documents and papers aiming to promote the necessity of partnership approaches to the tackling of complex social problems, for example social exclusion. In the field of health in Scotland in particular, there has been the White Paper "Designed to Care" (1997) emphasising the need for co-operation and collaboration within the NHS and with outside agencies, and the Green Paper "Working Together for a Healthier Scotland" (1998) calling for partnership between sectors to improve health in Scotland. Prior to this, in the 1980s at a national level Britain signed up to the WHO Health for All 2000 initiative which translated into the 'Health of the Nation Targets'. In addition Goss and Kent (1995) highlight a new emphasis on 'health gain', in which Health Board Health Commissioning

Teams are expected to work closely with local authorities, particularly the social services and housing and the voluntary sector. Government guidance has also encouraged the development of 'health alliances' between a range of different agencies.

It can be argued that political motives exist behind some of the exhortations for collaboration. For example the Conservative governments' emphasis on decreasing the role of the state in provision, on the introduction of market mechanism and privatisation can be seen in the fragmentation of the public sector into a myriad of agencies and contracting relationships. As Huxham (1996) notes, political motivations can be seen in the emphasis attached to the development of public-private partnerships, in the hope that private sector managerial 'good practice' will rub off on the public sector, and in terms of contracting, that competition will create greater efficiency. (1996:3)

Calls for multi-agency working are not new, however. Whyte (1997) has traced the historical roots of the need for organisations to work together to the Kilbrandon Report (Scottish Home and Health Department 1964) which in relation to 'juvenile delinquents' emphasised the importance of partnership between education and social welfare services involving multi-disciplinary collaboration, joint assessment and joint community based service provision. In a similar way Higgins *et al.* (1994) note that inter-agency working and inter-professional collaboration are key principles within British community care legislation. For example the Griffiths Report (1988) and the White Paper "Caring for People" (1989) were the latest in a long line of recommendations for the development of a 'seamless service' for service users dating back to 1972. In other policy contexts such as area regeneration, a partnership approach has a long established history. Such arrangements are now the norm.

Thus it may be argued that the advocating of multi-agency solutions to tackling social problems and improving service delivery has a substantial history within public policy at a national level. However, a common concern within the literature is the lack of guidance provided for the effective development of such initiatives, and in addition the perceived contradiction of calls for collaborative working in an environment simultaneously characterised by increasing competition.

2.6.2 What is multi-agency working?

No definition of multi-agency working has been located within the literature. In fact, in much of the literature where the word multi-agency is used it is used inter-changeably with other terms such as 'inter-agency' working (for example Hague *et al.* 1996). Huxham (1996) discusses the range of alternative terms for inter-organisational working. She divides them into positive terms, such as 'collaboration', 'co-operation', 'co-ordination', 'alliance', 'coalition', 'network', 'partnership', and 'bridge'; and those with negative connotations, such as 'conflict', 'competition', 'co-option', and 'collusion'. Huxham states that

While such distinctions have value in principle, there seems to be little consensus in the field about how the terms are used either in theory or in practice, so they do not provide a consistent framework. Indeed ... a vast variety of definitions are attributed to 'collaboration' alone. (1996:7-8)

A degree of similarity can be seen between the different terms. For example Arblaster *et al.* (1996) in a study of inter-agency working to address the housing health and social care needs of people in ordinary housing, define collaboration as,

a partnership of joint working between different authorities and/or agencies involved in the planning and delivering of services (1996:v)

In addition Arblaster *et al.* (1996) define joint commissioning as

when two or more commissioning agencies act together to co-ordinate their commissioning, taking joint responsibility for translating strategy into action to achieve better outcomes for users and carers. (1996:vi)

One explanation for the array of terminology is that the literature derives from a variety of academic disciplines, such as policy science, organisational theory and political science (Sanderson 1990), and the concept is developed in a variety of policy contexts with different professional backgrounds. As such the emphasis on the relationship between organisations and the types of organisations involved differ. Relating to the variety of academic disciplines, some authors suggest that there exists a 'theoretical proliferation' in relation to inter-organisational working (O'Toole 1986), resulting in contrasting theoretical

perspectives, for example, rationalist versus incrementalist, pluralist versus structuralist, rational-functional versus radical organisational theory (Sanderson 1990). The result, according to Sanderson, is “*a rather confusing range of findings (some of which are contradictory) which provide little clear guidance to effective implementation in a multi-actor context*” (1990:3).

In contrast some authors argue that lack of clarity persists due to the absence of a theoretical framework (Hudson 1987; Huxham 1993a). Much of the literature available on multi-agency working, particularly in relation to public policy, is topic based, discussing examples in particular fields such as child sex abuse, domestic violence, housing and health, and community care, either reviewing the experience of organisations trying to work together, or recommending a multi-agency approach as a solution. Huxham (1993) has argued that the increasing emphasis on the need for organisations to work together within the policy literature and within government directives has not been effective because the ‘push for partnership’ has not been informed by research on organisations. A result is that analysis of specific initiatives usually occurs in a theoretical vacuum and little elaboration is given about what multi-agency working, as a strategy and action, is intended to be.

What the differing definitions have in common is the involvement of a range of actors from different organisations and sectors working together. As such, for the purposes of this research, multi-agency working is employed as an umbrella term to refer to organisations working together in a variety of different ways and at a number of different levels, of which the other terms highlighted earlier exist as varying types. For example inter-agency working will be considered as one form of multi-agency working. Since the literature reviewed concerns a variety of forms of multi-agency working, the terminology used within the discussion will be that of the authors concerned. The variety of differing characteristics of these relationships as identified within the literature is discussed below.

2.6.3 Typologies of multi-agency working

Given the plethora of terminology it is perhaps unsurprising that there are a range of possible ways in which organisations can work together, which can be categorised under

the following five headings: motivations; degrees of formality, scope, rationale and activities and outputs.

2.6.3.1 Motivations

Collaborations can be voluntary or directed, which to a degree affect the other characteristics of the arrangement. Voluntary arrangements, what Hudson (1987) terms 'co-operative strategies' develop when organisations recognise the existence of shared concerns and the 'collaborative advantage' (Huxham 1996) to be gained through working together, and are characterised by negotiation and exchange. Huxham (1996) notes that these voluntary collaborations resulting from an acknowledgement of the complexity of social problems can be motivated by participants seeing them as being to their own advantage as well as out of an altruistic concern for the 'greater good'. (1996:2). Directed collaborations, can either be 'authoritative' (Hudson 1987), that is directed by a dominant legislative body, such as central government, to engage in an activity, as is the case in joint planning arrangements between health and social services; or 'incentive strategies' (Hudson 1987) where conditions are manipulated to remove constraints and encourage collaborations, such as through changing legislation and regulatory arrangements.

2.6.3.2 Degree of formality

The degree of formality of multi-agency working reflects the motivation for organisations working together. For example collaborations developed as a response to a statutory requirement for organisations to work together tend to be highly formalised arrangements with a prescribed range of participants and remit to be addressed (Huxham 1996). At the other end of the spectrum, voluntary collaborations tend to be less formalised, in which the membership and remit of the collaboration may be more flexible and evolving.

2.6.3.3 Scope

The scope of multi-agency initiatives vary in geographic scale, the breadth of change desired and the time-scale applied. In relation to geographic scale, multi-agency working can range from national and international networks of national and/or local level actors, of which the European Healthy Cities Project is an example, to local level arrangements centred on community development and participation. Similarly the breadth of change of

multi-agency initiatives can range from those seeking to identify solutions to 'macro' problems requiring social, economic and environmental change, to 'micro' level initiatives seeking to address a particular issue within a particular community. Initiatives can also be time limited or open ended; this dimension depends on both the scope of the project and the action it is seeking to initiate or develop.

2.6.3.4 Rationale

The rationale of multi-agency working, relates to the motivation for the initiative, which can develop in response to a positive opportunity, or an identified threat or problem (Butterfoss *et al.* 1993).

2.6.3.5 Activities and Outputs

The expected activities and outputs of multi-agency working arrangements also vary between tangible and intangible. Some initiatives will be developed with the expectation of realisable outcomes or improvements, such as in service delivery or health status. Others concern encouraging participation, improving relationships and creating a climate more conducive to collaboration in policy-making.

As can be seen there are a variety of ways in which the process of organisations working together can be conceptualised. The relationships can be formal or informal, may involve integration or the setting up of separate project, and may or may not involve the allocation of finance or other resources. Common themes emerging from these accounts are the importance of structural factors, both within and between organisations and in the broader social, political and economic context, and of agency factors, such as the willingness and motivations of the organisations, and the individuals within them.

2.6.4 Conditions for multi-agency working

A number of authors have developed frameworks for understanding the conditions required for effective multi-agency working. Rather than presenting a range of 'ideal types', the majority of authors suggest a 'fitness for purpose' approach (Hambleton *et al.* 1995) depending on the prevailing circumstances.

Several authors note that for successful multi-agency working to take place there has to be a willingness of organisations to co-operate (Alter and Hage 1993). Huxham (1993b) suggests that organisations need to demonstrate 'collaborative capability', which she argues will depend on the degree of autonomy of organisations and individuals, the cohesiveness of organisational structures, the development of strategic processes and elaboration of strategic aims, and the importance of collaboration to the organisation. Hudson (1995) notes that collaboration often involves changing relationships between organisations and as such there is a need for flexibility, particularly where there are differences in organisational status.

The characteristics of the participating organisations are seen as central to the success of multi-agency working. Some authors suggest the need for 'interorganisational homogeneity' (Hudson 1987). Thus multi-agency working is facilitated where organisations demonstrate structural and functional similarity, as differences may lead to obstacles in the process. In contrast, other authors such as Alter and Hage (1993) classify such homogeneity as leading to 'competitive collaboration', which may be perceived by participants as threatening, particularly if associated with the rationalisation of service provision. Rather they suggest that 'symbiotic' collaboration, where participants provide different functions to a shared goal, may produce a more successful collaborative relationship.

Related to this several authors suggest the need for 'domain consensus' (Hudson 1987), which comprises the existence of a clear set of expectations, an agreement on goals, and agreement amongst the professionals of their position within a hierarchy of professions (Hudson 1987). Harrison and Tether (1987) identify three potential motives for policy co-ordination: reduced costs in relation to 'going it alone'; to avoid wasting resources through a duplication of effort or contradictory policies; and to minimise 'externalities' resulting from the unintended consequences of policies (1987:78).

A fourth issue raised is that the organisations recognise their interdependence in the realisation of aims and goals. This has been termed variously 'network awareness' (Hudson 1987) and 'stakeholder interdependence' (McCann and Gray 1986). Huxham

(1996) has developed a concept of 'collaborative advantage' - the ability of organisations to achieve something together which could not have been achieved by the organisations individually - which she argues can increase the legitimacy of the activity as worthy of investment (1996:15). Related to this, Hudson (1987) suggests is the need for 'organisational exchange', based on the notion of reciprocity, that participants must perceive the exchange as being in their favour. Authors highlight the importance of power relations between organisations. Hudson (1987) suggests that whilst equality of power is not a precondition for exchange, no party should dominate or appear powerless in relation to the others. McCann and Gray (1986) argue similarly that collaboration is more likely to occur when power is dispersed amongst the actors.

The availability of resources is also raised by authors. Several authors highlight the need for adequate resources to be available in order that the goals of the partnership are realised (Alter and Hage, 1993; Arblaster *et al.* 1996). Whilst some authors highlight the provision of financial incentives as an enabler of collaboration, Hudson (1987) suggests that the availability of outside sources of funding to individual organisations will reduce the incentive to collaborate and develop 'exchange relations' with other organisations within the network.

Related to the issue of resources and 'collaborative advantage', several authors argue for the need for 'adaptive efficiency' (Alter and Hage 1993), that organisations need to see a return on their investment in the multi-agency process within a reasonable time-frame. Hambleton *et al.* (1995) suggest that the effective delivery of functions is particularly important where there is a statutory requirement for multi-agency working, whilst for voluntary arrangements the emphasis is placed more on the accountability of an initiative, to the public and elected members.

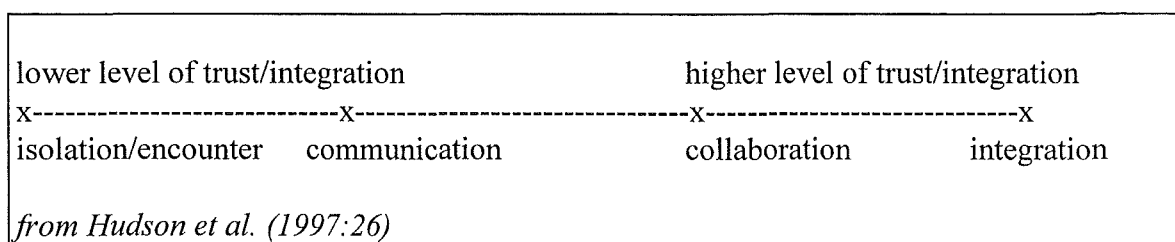
A range of operational issues are also raised. For example, Alter and Hage (1993) suggest that there needs to be the appropriate level of expertise amongst participants, and Hambleton *et al.* (1995) argue that the process should incorporate monitoring and review strategies. A number of authors researching multi-agency initiatives have identified a lack of 'role awareness' (Whyte 1997), and guidance (Hague 1997), and suggest the need for

support and training for participants and the use of third-party facilitation (Hague 1997).

A number of authors highlight the importance of individual agency to the successful outcome of multi-agency working. Hudson *et al.* (1997) comment on the importance of 'individual entrepreneurialism' as 'champions of change' (McCann and Gray 1986). Similarly Friend *et al.* (1974) and Webb (1991) stress the importance of 'reticulists', individuals who are skilled and sensitive to bridging interests, professions and organisations, who may work formally in such a role or informally, and develop or use existing boundary spanning networks (1991:231).

Finally, and perhaps the most crucial characteristic for successful multi-agency working is the establishment of trust between the participating organisations (Alter and Hage 1993; Hudson *et al.* 1997). Hudson *et al.* (1997), studying working alliances across the primary health care / social care boundaries, developed a 'collaborative continuum' of the interface based around two key dimensions: degree of integration and degree of trust. This is represented in diagrammatic form in Figure 2.1. Four distinct points on the continuum are identified: isolation/encounter, communication, collaboration and integration. The diagram seeks to demonstrate that the higher the level of trust between organisations, the greater the degree of integration.

Figure 2.1: Hudson et al.'s collaborative continuum.



2.6.6 Limits to multi-agency working

Despite the common claims for the benefits and necessity of multi-agency working, several authors are more sceptical about the ability to realise such goals. As Hudson (1995:235) comments in relation to joint commissioning between health and social services

All of this adds up to an agenda high on promise and ambition, the attainment of which would be tantamount to an organisational revolution in health and social care... this alone suggests that enthusiasm needs to be tempered with caution and some scepticism. (1995:235)

Both Huxham (1993) and Goss and Kent (1995) comment that there is little evidence of effective collaborative working. Arblaster *et al.* (1996) in their research into inter-agency initiatives between housing, health and social care agencies conclude that whilst there were many examples of **two** organisations working together, there was little evidence of **three-way** links. Others concluded that whilst formal links between organisations may be established at a strategic level, this was not reflected lower down within the organisations, particularly in relation to service delivery (Arblaster *et al.* 1996). Some authors, whilst highlighting improvements in levels of awareness and information-sharing as a result of networking, concluded that without improvements in services, forums were at risk of becoming 'talking shops', and not worth the effort involved in the process (Hague 1997).

Huxham (1993) identifies three main groups of barriers to collaboration, which can lead to collaborative inertia. Collaborative inertia is defined as,

The situation when the apparent rate of work output from a collaboration is slowed down considerably compared to what the casual observer might expect it to be able to achieve. (1996:3)

The tensions are, "*differences in aims, language, procedures, culture and perceived power*"; the tension between autonomy and accountability and the lack of authority structure; and the time needed to manage logistics (1996:5-7).

A number of problems associated with organisations working together have been identified within the literature, presenting limitations to the successful outcome of initiatives. These have been summarised as: organisational structures; fragmented organisations; organisational cultures; competitive culture; power; and operational issues.

2.6.6.1 Organisational structures

Organisational boundaries were highlighted as a barrier, particularly in the case of funding and public accountability. This links in with the problem of defined remits and the impact

on whose responsibility it is to do what. For example Goss and Kent (1995) noted a tension between organisations on whether health funds should be spent on housing, despite the accepted link between poor housing and health. In a similar way to the issue of departmentalism within individual organisations, several organisations commented on the tendency of organisations to “*defend their own turf*” (Hague 1997:95).

Hambleton *et al.* (1995) comment that the in-depth skills and knowledge of local authority officers can equip local government to play an effective role in a wider network of joint working (1995:62). However their research highlighted the difficulties of “*entrenched departmental and professional attitudes*” which can work against effective interagency collaboration, and also that “*local authorities may see interagency working as an “add on”, as a peripheral issue to the local authority itself*” (1995:62-63). Other problems encountered were the methods of reporting back, crucial for accountability so that the arrangement does not become peripheral to the work of the authority. This was considered to be particularly true for voluntary arrangements where the activity is not seen as part of the mainstream work.

As Webb (1991) suggests the maintenance of organisational divisions and boundaries is to be expected as

*the civil service tradition primarily operates to preserve and entrench division of labour and to limit conflict by reinforcing agreed domains. The pursuit of **complex policies** is all too easily sacrificed to the preservation of that division of labour and respect for domains which underpins orderly, day-to-day administration*
(1991:231) (author's emphasis)

Other structural barriers identified within the literature related to power differences, particularly between statutory and voluntary organisations. A further related issue was the increasing ‘fragmentation’ of organisations.

2.6.6.2 Fragmenting organisations

The increasing organisational fragmentation is seen as a barrier to organisations working together as well as a factor in its increased occurrence. The increasing number of organisations with a legitimate interest in an issue impacts on the ability of a process being

inclusive and on the ability to reach shared goals or policy agreements. Goss and Kent (1995) comment that the increase in number of agencies involved in social housing make difficult to achieve a common approach to policy or strategy.

Hambleton *et al.* (1995) comment that the changes introduced can be perceived as a threat to local government, through the diminishing of its functions and threat to its authority. As such, particularly in the context of cost-cutting, collaboration may be responded to defensively or even resisted. The authors also note that further fragmentation of decision-making / service delivery may lead to a situation where it undermines the collaboration as it may produce unmanageable numbers of agencies with smaller budgets. In addition Goss and Kent (1995) note that whilst in theory the establishment of unitary authorities should make it easier to establish links, in their example between housing, social and health services, the near constant organisational restructuring and consequent changes in personnel can have a damaging effect on relationships and networks between organisations.

2.6.6.3 Organisational cultures

Several authors have highlighted problems associated with inter-disciplinary differences and professional rivalries in attempts to develop effective multi-agency working (Saks 1996). Sanderson (1990) has argued that the commitment of professionals to particular ideologies can act as an impediment to collaboration. Hudson (1995) highlighted deeper tensions around ideologies of health and differences in what members consider to be priorities and appropriate action. Whyte (1997) has highlighted the tendency of dominant professional cultures to lead to the “*compartmentalization of roles*” (1997:698). As such efforts towards multi-disciplinary working can often lead to the development of ‘role confusion’ due to conflicting professional status and team-loyalty.

2.6.6.4 Competition

As several authors have noted, policy changes at a national level calling for organisations to work together have occurred simultaneously with a growing emphasis on the introduction of competition and market mechanisms within the public sector and between organisations. Arblaster *et al.* (1996) note the contradiction of the government exhorting

agencies to work together at the same time as introducing policies which work against that process, for example the purchaser/provider split, changing roles and responsibilities creating confusion and administrative complexities. Concerns have been raised by several authors that this introduction of competition will lead to a reduction in the range of services offered and increase the gaps in provision, rather than produce the 'seamless service' or co-ordinated response which is often aspired to. As Arblaster *et al.* comment

The introduction of competition tends to lead to a narrow, specialist approach to services, and to increased separation of agencies. This does not encourage an integrated holistic approach to service provision. The emphasis on making agencies more 'accountable' for their performance tends to focus agencies on narrow indicators, which do not reward collaboration or support long term goals. (1996:ix)

The Working Party Report (1993) of the Local Government Management Board notes that changes within individual organisations and the organisational landscape make it hard to build and sustain relationships as it is becoming increasingly difficult for one organisation to keep up to date with changes occurring in another

An emphasis on competition between agencies and on short-term measures of performance discourages the investment of time and know ledge required to develop joint working (1993:43)

However as Whitelaw and Wimbush (1998:9) argue

It could be argued that the existence of a hostile environment should not stand in the way of progressing partnerships and that indeed it should provide a motivation (1998:9)

2.6.6.5 Power

Inequality of power between organisations and professions was frequently raised by authors as an obstacle to multi-agency working. Hague (1997) notes that voluntary organisations often feel marginalised within multi-agency initiatives, and users of the services are invariably not represented. She comments that there can be problems trying to equalise power difference between agencies, dealing with conflicts between them in terms of differing roles and philosophy, and avoiding protective or defensive responses. She argues that these power differences are hard to overcome, especially with the tendency of large statutory agencies to attempt to 'own' the work done or take over. The impact of

power differentials have been argued as particularly important within voluntary arrangements which tend to suffer greater instability (Hambleton *et al.* 1995).

2.6.6.6 Operational Issues

A number of operational limitations were also raised by authors. Multi-agency working was considered to be a time consuming process, and frequently characterised by communication difficulties, particularly within voluntary arrangements (Hambleton *et al.* 1995). Further the sheer complexity of the problems that it seeks to address add to the complexity of working to develop solutions (Hudson 1995).

Related to the mixed messages emerging from the national policy arena is the concern of several authors that exhortations for organisations to collaborate and find innovative ways of working are being made in a context of increasing resource shortages. The LGMB Working Party Report (1993) comments that financial cuts and reductions to services create distrust within organisations which does not produce an environment conducive to the co-operation that inter-agency work requires (1993:44). As Hambleton *et al.* (1995) have noted, resources can play a critical role, acting as a spur to collaboration, particularly if it is a financial prerequisite. At other times resources may be a constraint,

For local authorities under pressure, belonging to external organisations, particularly where there is no statutory requirement, can some times be viewed as a luxury ... It is often hard to sustain existing voluntary joint arrangements where overall budgets in local authorities are constantly being cut. The ability to keep everyone 'on board' is in constant danger, where total budgets are decreasing and the joint arrangement is discretionary rather than mandatory. (1995:67)

A further related problem highlighted was the lack of guidance and training for organisations and members about how to develop effective relationships. Several authors comment that central government has issued little in the way of information on how organisations should go about working together, and how the problems faced should be overcome. In recent years, this situation has been improving, for example the Home Office 1996 report on multi-agency responses to racial harassment, and Home Office inter-agency circular on domestic violence (Home Office, 1995).

In summary, authors have argued that there is confusion or even contradiction in the policy

changes and the mechanisms developed to implement multi-agency working. Significant amongst these is the fragmentation of the public sector, and the call for co-operation between agencies whilst simultaneously trying to introduce competition. A further issue is the call to undertake innovative work in a climate of increasing resource shortage. Competing organisational and professional cultures and inequalities in status and power were also highlighted.

2.6.7 Gender and multi-agency working

In common with the mainstream literature on the policy process and organisations, gender is largely absent as a consideration in accounts of multi-agency working. However a number of authors have highlighted the importance of gender within multi-agency development and practice (Hague 1997; May 1997; Sampson *et al.* 1991).

In relation to urban regeneration initiatives, May (1997) comments that gender is absent both in theoretical analysis and in the practice of mainstream urban regeneration work. She notes that gender awareness is not a requirement in urban regeneration partnerships, and despite the fact that there is common agreement that women are more likely to be involved in community regeneration than men, their centrality is not reflected in research or policy development and as such their needs and potential are overlooked.

Sampson *et al.* (1991) in their research on inter-agency co-operation in relation to the criminal justice system note that women probation officers and social workers in interviews about inter-agency relations frequently and spontaneously mentioned experiences of sexual harassment from both the police and prison officers. In addition women interviewees highlighted experience of marginalisation through being excluded from informal networks and information-sharing, limiting their effectiveness to do their jobs. Sampson *et al.* comment that the existence of gender discrimination can be an obstacle to interagency working as women may withdraw or take avoiding action in some forms of interagency working as a mean of minimising discriminatory encounters. However, they argue, can also lead to the development of innovative working relationships as women try to develop alternative forms of alliances with organisations to counteract their marginalisation, for example women's informal networks,

The actually existing inter-agency relations between the police, social services and probation service in a court setting provide particularly clear evidence of how sexual discrimination and harassment can accentuate the differential power relations between these state agencies, while also inhibiting certain forms of inter-agency contact and promoting others. (1991:127)

As such gender can be argued to be as significant an issue in relation to organisational structures and cultures, between as within organisation.

2.7 Summary

This chapter has sought to review a diverse range of literature, all of which relates to the central research aim of this thesis – to examine the implementation of the WHP as a case-study of multi-agency working. Throughout this chapter I have sought to identify issues of potential relevance to the analysis in this thesis. In this final section I shall draw out the key themes emerging from this review.

A common theme emerging across the literature has been the feminist critiques of the presumed objectivity, rationality and gender neutrality of definitions, policies, strategies and organisations within the mainstream literature. Such critiques vary widely depending on the feminist perspective employed. However, most highlight the role of social values and subjective assumptions within policies and organisations, and thus the important influence on culture on these presumed neutral structures. Indeed, in some accounts, culture and structure are seen as interdependent, each reinforcing the other. As a result, authors have asserted the centrality of power, and of the social construction of the categories ‘women’ and ‘gender’, and the role these have in relation to the implementation of policies within organisations.

Central to these debates is the notion of power, and its location in culture and organisational structures. Much of the literature points to the marginalisation of women and ‘women’s issues’ within policy and organisations. As such, women’s experiences of health have been ignored; women are largely segregated into the less powerful positions within organisations; and ‘women’s’ policies and initiatives suffer from a lack of status, authority and political commitment within organisations.

More positively, however, analyses have highlighted the importance of difference, flexibility, and the possibility for change. For example, the importance of individual agency, of networks and coalitions have been highlighted. The themes of gender, power, structure, agency and culture will be central to the exploration of the processes associated implementation of the WHP. First, within the next chapter, the research design and methodology used in this work are explained.

Chapter 3 - Research Design and Methodology

3.1 Introduction

This research proceeds from an interpretivist stance perspective, analysing the implementation of the Glasgow Women's Health Policy as a case-study of multi-agency working. As such the research does not begin with a prior hypothesis or theory to be 'tested' through the analysis, but rather utilises a variety of qualitative methods to explore the case-study, to build an explanatory account of the influences, both positive and negative, on the implementation process and on multi-agency working. The analysis draws upon social constructionist and feminist theoretical perspectives.

This chapter outlines the mechanics of the research process, namely how the research was approached, the methods chosen, the research strategy employed and how the research progressed. First the origins of this research are discussed to provide some context to the approach taken. This is followed by a brief review of the theory of social research, and research methodology, focusing on the case-study method. A detailed discussion of the research design and strategy is provided, reviewing the decisions made, the relative strengths and weaknesses experienced and the obstacles and enablers encountered. Following a review of the approach taken to the analysis of the data, and the issues of reliability and validity, the final section reflects on the particular experience of this research for the researcher.

3.2 The origins of the research

Prior to any discussion of the research methodology and design, it is important to raise a number of issues concerning the nature and origin of this research. This will provide an important context to the subsequent sections in this chapter.

The research on which this thesis is based was carried out as part of an ESRC CASE studentship. This type of studentship differs from the traditional form of ESRC doctoral funding in two respects. First, the research takes place with the aid of an 'industrial

sponsor', in this case Greater Glasgow Health Board. In addition to financial assistance, the sponsor also is involved, through a named representative, in the supervision of the research. Second, the academic and 'industrial supervisor' are responsible for devising the research area and the research questions, and bidding for the studentship. As such, my involvement in this research began after a broad remit for this research had been set.

This, to a degree, informs the direction that the research has taken the WHP as a single case-study, and also the approach taken. For example, the aim of the research and the research questions were established prior to my conduct of a substantial part of the literature review. This is reflected in the exploratory nature of this research.

A further issue concerns the close involvement of my supervisors as both the originators and, to differing degrees, the subjects of my research. These aspects of the research presented a range of opportunities, but also challenges, as will be discussed further at the end of this chapter. First, however, the research methodology and design is explained.

3.3 Theories of Social Research

Social research is typically identified as having two contrasting 'schools' or approaches: positivistic and interpretive. Although there arguably exists a range of positions between these two approaches, the stance taken will have a major impact on both the aims, methods, and outcomes of research. The positivist tradition, as associated with theorists such as Comte, Durkheim, Popper and Parsons, posits that society can be measured 'objectively', arguing that methods for analysis in natural science can be appropriated to social science. Within this tradition the search is for a 'reality' or set of 'social facts' or 'social structures' that can be objectively identified. In contrast, theorists such as Weber, Goffman and Garfinkel from the interpretive tradition seek,

not so much explanations and predictions of social events as understanding what meaning and significance the social world has for the people who live in it.
(O'Brien 1993:7)

The emphasis here is on 'social constructs'. To a degree adherence to one or other of these tradition determines the research methods chosen, with positivists most likely to utilise

quantitative, survey or experimental research, whilst interpretivist research is commonly associated with qualitative methods such as unstructured interviews and observation.

A further distinction can be drawn on the approach taken to the research and the analysis prevailing. The positivistic tradition is associated with the hypothetical deductive model, which advocates the logical deduction of hypothesis from general theories which are then tested through empirical research. Emphasis is placed on the generalisability of research findings, which are again most commonly associated with quantitative research which tend to use large samples or data sets. In contrast the interpretive tradition is associated with theory development through induction, that is, moving from a series of observations to the creation of a theory. Emphasis is placed on the depth of understanding and is commonly associated with qualitative research.

An inductive approach to analysis is considered to be best suited to this research due to its exploratory nature. As has been highlighted within the introductory chapter, the WHP represents a unique policy and a unique attempt to implement a social model of women's health within a local policy context. In addition, as has been highlighted within Chapter 2, there is little by way of existing studies or theories to provide the basis for a comparative or theory-testing analysis. Also, local government reorganisation meant that, for practical reasons, the fieldwork had to start earlier than would otherwise have been the case.

However, whilst the emphasis is on 'theory generation' as opposed to 'theory testing' as no explicit theoretical perspective has been adopted in approaching the analysis, it is not 'theory-free'. In adopting an interpretivist stance it may be argued that a 'theoretical' decision has already been made in seeing the purpose of research as being to explore 'social constructs' rather than being a search for 'social facts'. In addition the research is informed by a variety of feminist perspectives which have been instructive in the approach taken to the research and the interpretation of the data.

Two somewhat contrasting feminist perspectives have been drawn upon in developing the analysis: socialist feminism, and post-structuralist feminism. Socialist feminism provides a structuralist analysis of 'women's oppression' as produced and reproduced through

systems of patriarchy and capitalism, highlighting the importance of power, structure and agency in the persistence of gender inequality. Whilst this perspective offers the ability to contextualise the implementation of the Women's Health Policy within the dominant discourse operating in society, perceived limitations include the binary opposition of male versus female, limiting analysis of differences between women and between men; and the tendency to offer determinist conclusions in prioritising structure over agency. For this reason, post-structuralist feminism, particularly the variant deriving from discourse analysis, provides an insightful critique in focusing on the processes through which gender hierarchies are constructed and legitimised as opposed to their origins. In addition such an approach highlights the diversity of experience through the inclusion of 'subjectivities', and through an analysis of power, culture and agency, offers opportunities for resistance through the production of alternative discourses, in contrast to determinism through structure.

3.4 Research Methodology

In taking an interpretivist approach, the research comprises of a qualitative, case-study methodology. In addition consideration was given to the appropriateness of a separate feminist methodology. Within this section the reasons for the adoption of this methodology are discussed.

3.4.1 Qualitative research

As Bryman (1989) notes, within qualitative research the emphasis is on,

the perspectives of those being studied rather than the prior concerns of the researcher, along with the related emphasis on interpretation of observations in accordance with subjects' own understandings. (Bryman 1989:135)

Bryman (1989) identified a further six distinctive features of qualitative research, which make it the appropriate methodology for this case-study research. These features are: delineation of context; emphasis on process - the unfolding of events over time; flexibility and unstructured - little prior theoretical orientation and no hypothesis; three primary sources of data - fieldnotes of observations, unstructured interviews, and documents;

viewing phenomena as socially constructed; and obtaining and retaining close proximity to the phenomena.

Each of these elements to a greater or lesser degree have played a significant role within this research. Of particular concern was the analysis of process, as the research examines how and why the Women's Health Policy was developed and how and why (or why not) the policy was implemented within the organisations. Qualitative analysis affords this through its concern with context and the common use of multiple methods, such as observation, interviews and documentary analysis.

In contrast as Bryman (1989) notes, the analysis of processes within quantitative research is less dynamic and “*often entails fairly static analyses in which relationships among variables are explored*” (1989:140). Quantitative analysis is also less suited to the exploratory nature of research such as this, as quantitative research demands the prior decisions on hypothesis, the rigorous construction of a framework in which the research is to be conducted, which arguably determines the scope for the analysis at the outset rather than being open to the possibility of new ideas emerging.

Bryman (1989), focusing upon qualitative research within organisational studies, has developed a typology of four types of research which differ as to the level of the researchers' participation within the organisation(s), the primary source of data collection, and the number of cases studied. These four types are: total participant; semi-participant; interview based; and multi-site. This research is most closely aligned to type three, interview based research, in which semi-structured interviews and documents are the main sources of data collection with observation being largely non-participant with the researcher on the “*periphery of interaction*”, and conducted, “*mainly to augment interviews and documentary analysis*” (Bryman 1989:155-156) As Bryman (1989) notes such research tends to be more structured, with the researcher having a less participatory role within the organisation which may limit the depth of understanding of the subjects' perspectives and interpretations. However the retrospective element of this research necessitates a greater reliance on interviews and documents.

3.4.2 Case-study research

This research comprises of a single case-study - the implementation of the Women's Health Policy - which due to the multi-agency aspect has involved analysis within and between a number of organisations. Hartley (1994) has defined case study research as involving,

a detailed investigation, often with data collected over a period of time, of one or more organizations, or groups within organizations, with a view to providing an analysis of the context and process involved in the phenomenon under study. The phenomenon is not isolated from its context ... but is of interest precisely because it is relation to its context. (1994:208-209)

According to Yin (1989) case-studies are not a method in themselves but a 'research strategy'. They can be either descriptive, explanatory or explorative, and are a preferred strategy when 'why' or 'how' questions are being asked, when the researcher has little control over events, and when the focus is on contemporary phenomena within a real-life context. This research involved a process of moving from description - understanding the case - through exploration in data collection, to the development of an explanatory account.

There are several aspects of case-study research which lend it to being an appropriate method for this research. There is usually strong emphasis placed on the context surrounding the case, and the usually prolonged involvement of the researcher with the case such that events can be traced over time and inferences made about processes. In addition Bryman (1989) has argued that their role in policy research has been increasingly recognised as "*they are able to illuminate the effects of implementations on everyday activity*" (1989:172).

In research such as this where the focus will be on one case rather than a comparative multiple case study, the utilisation of multiple methods to gain information from different sources benefits the research by increasing the construct validity. As Hartley (1994) notes,

Many case study researchers, in their pursuit of the delicate and intricate interactions and processes occurring within organizations, will use a combination of methods, partly because complex phenomena may be best approached through several methods, and partly deliberately to triangulate (and thereby improve validity). (1994:209-210)

Within case study research the emphasis tends to be on theory generation through the in-depth analysis of the case(s), and the prominence given to process and context. As Hartley (1994) argues,

The opportunity to explore issues in depth, in their context, means that theory development can occur through the systematic piecing together of detailed evidence to generate (or perhaps replicate) theories of more general interest.
(1994:211)

One advantage of case-study research is the depth and colour that can be gained in the analysis of social processes, such that “*readers feel that they know what is like to be in the organisation being studied*” (Bryman 1989:172). A disadvantage is that the gathering, generation and analysis of data can be very time-consuming. In addition case-study research has commonly been criticised for its lack of generalisability - the ability to apply the analysis to other contexts or settings - and thus their validity and replicability. Several authors have attempted to address these criticisms (Mitchell 1983; Stoeker 1991; Yin 1989). Whilst Stoeker (1991) argues for a redefinition of the case-study, having a more explicit theory component and employing ‘collaborative methods’, Mitchell (1983) has argued that much of the criticism is based on a misconception of interpretive or inductive analysis.

In case-studies statistical inferences is not evoked at all. Instead the inferential process turns exclusively on the theoretically necessary linkages among features of the case-study. The validity of the extrapolation depends not on the typicality or representativeness of the case but on the cogency of the theoretical reasoning.
(1983:207)

In addition, Yin argues that “*case-studies, like experiments, are generalisable to theoretical propositions and not to populations or universes*” (1989:21) and thus its lack of replicability does not hinder its value in developing an understanding of social processes. Yin’s argument reflects the approach taken within this research. As an analysis of a single case-study, the primary concern of the research is not its generalisability to other settings, but an understanding of the processes associated with the case. However, in comparing the research findings to those in other areas, a degree of clarity is afforded to those aspects with are particular to the case and those more common to a variety of contexts.

3.4.3 Feminist Research

A range of contrasting literature exists on the topic of feminism and feminist research, reflecting the diversity of arguments and theories contained under the umbrella of feminism. The ongoing debate within feminist research concerns arguments for the need for or existence of a separate feminist methodology or epistemology. Much of the debate stems from the perceived inadequacy of existing research methods in social science to document women's lives, of the status given to the criteria of objectivity over subjectivity and the role of reflexivity in research. Stanley and Wise (1993) for example see objectivity as an unobtainable goal, arguing that all research is 'fiction' as the 'reality' is constructed through the researcher's interpretation, and stress the importance of experience and reflexivity in research.

Oakley (1990) notes how research methods are commonly distinguished as masculine and feminine, and that feminist research is often considered to rely exclusively on qualitative methods. However, as Oakley argues, to restrict the research methods is to restrict the type of questions that can be asked. Eichler (1988) considers there to be four 'primary problems' which lead to sexism in research: androcentricity, over-generalisation, gender insensitivity and double standards. These problems, it may be argued, stem from the researcher and their analysis rather than the methods.

The feminist debate about research is important and illuminating. However there is little difference in the points made in some accounts (e.g. Stanley and Wise 1993) and the wider debate that exists within social research between positivist and interpretivist social science, their respective methodologies, and arguments of what is considered permissible as evidence. It is not the methods that incorporate sexism but the questions they are asked to address. These questions derive from the theoretical perspective and hence the importance of feminist research rather than a need for a separate feminist methodology. As Morgan (1981) argues,

The permeation of sociology by sexist background assumptions is less the product of the adoption or failure to adopt a particular methodology and much more a product of the social relations of sociological production... sexism is as much to do with the ways in which taken-for-granted notions of 'men' and 'masculinities' are handled in sociological enquiry, notions which are frequently manifested in

absences and silences, as it is with the way in which women are ignored or stereotyped in such work... such considerations matter for the reason that had such assumptions and notions been confronted and explored, the outcome of the enquiry under examination might have been very different or might have been the fruitful source of new lines of enquiry. (1981:107-108)

In arguing that gender should be seen as a central variable in research, Roberts (1981) argues that feminists are calling for more, not less, rigorous research methods:

Good feminist research, rather than rejecting academic and scientific rationality, is proposing that we critically examine socially constructed notions of just what it is that constitutes scholarship and rationality ... to question principles and assumptions whose justification and explanation had a great deal to do with gender divisions and very little to do with the pursuit of knowledge (1981: xvi).

A feminist approach is incorporated within this research through the questions posed and the analysis undertaken rather than adopting or developing a distinctive feminist methodology.

It is often assumed implicitly, if not stated explicitly, that feminist research is about women and conducted by women. Initially this was obviously a central concern due to the dearth of research on women and women's lives in much of social science, and to challenge the notion that findings of research based on men could be unproblematically extrapolated to be those of the population as a whole. However, as feminist analyses have developed, the social construction of gender and its implications, the dichotomies have further been broken down, and the construction of masculinity, or 'masculinities' (Morgan 1981), as well as femininities need to be studied. As Layland (1990) notes,

The latent effect of seeing feminist research as exclusively about women's lives is that it allows things male to go uninvestigated, almost as though the idea of the male-as-norm were not being questioned anymore. However, we must demystify power and its components, one of which is the production of 'masculinity' and 'masculine' behaviour. (1990 :129)

Within this research the emphasis has been on understanding the gendered dimensions of policy implementation and multi-agency working. As is detailed in the following section, selection of interviewees was based on their involvement with the Women's Health Working Group or organisational women's fora, or their senior or strategic position within the organisations. Due to the composition of the groups analysed women formed the

majority of interviewees, with male interviewees predominantly occupying more senior positions outwith the fora.

3.5 Research design

All social research is subject to trade-offs; even when researchers do their hardest to dovetail research problem and research method or design, it is rarely possible to avoid certain pitfalls or disadvantages in the choice(s) made. In reality, much research entails an attempt to maximise 'damage limitation'. (Bryman 1989:158-159)

As has been discussed in Chapter 1, the research concerns the analysis of the extent of implementation of the Glasgow Women's Health Policy within the Glasgow Healthy Cities Project partner agencies, the enablers and barriers to that process, and an analysis of the processes involved in multi-agency working. Reasons for the selection of a qualitative case-study methodology have been outlined in the previous section. In this section the delimitation of the research focus is explained, before discussing the research methods and strategy within the next section.

As has previously been mentioned, the aims of the research questions were broadly determined at the outset of this research. These were:

- **To examine the extent to which the Women's Health Policy has been adopted and implemented by the Healthy City agencies.**
- **To identify the factors, both social and organisational, which have facilitated or hindered the implementation of the policy.**
- **To describe and analyse the processes involved in multi-agency working.**

The processes involved in implementation and multi-agency working and the enablers and barriers experienced were the most straightforward elements to design in terms of approach and questions. This was done through exploring the perceptions and experiences of those who were involved or connected with the policy process itself. In deciding how to examine the 'extent' of implementation, a problem emerged in that this can be viewed at a number of different levels: in terms of the implementation of key priorities in the document; of provoking debate, developing action; or achieving the central aim itself. It is

not the concern of this study to analyse the extent of the implementation as a social fact or reality, not least because one of the problems identified within the literature on Healthy Cities has been the lack of appropriate indicators to analyse a holistic concept of health (Hancock 1993). In addition there are no base-data available from which 'before' and 'after' measurements of the impact of the WHP could be taken. Neither is the research concerned with evaluating, from a 'top-down', rationalist perspective, the effectiveness of the Policy. Rather 'extent' is analysed in relation to the perceptions of interviewees and the context of the process identified, and backed by the 'tracking' of strategies and action through documentary analysis.

Several contextual changes occurred which impacted on both the research focus and design. When the research began in October 1995 there were three statutory partner agencies funding the Glasgow Healthy Cities Project: Glasgow District Council, Greater Glasgow Health Board, and Strathclyde Regional Council. In March 1996 local government reorganisation and the creation of Unitary Authorities reduced the number of statutory partner agencies to two: Greater Glasgow Health Board and the new Glasgow City Council. The year preceding reorganisation was also characterised by an abundance of change as staff were relocated to different authorities or leaving to pursue work elsewhere, and much of the focus of the work within Strathclyde Regional Council and Glasgow District Council concerned the winding up of activities and the development of new organisational structures.

The work of the Women's Health Working Group during the initial stages of the research was undergoing a period of review. Members of the WHWG were looking at options for restructuring the Group as a result of local government reorganisation changing the representation on the Group and a recognition of some problems experienced in developing work within the organisations. These issues will be discussed further in Chapter 4 on organisational structures.

In addition the Glasgow Women's Health Policy which had been formally adopted by the Glasgow Healthy Cities Project partner agencies in 1992 was also undergoing review for two main reasons. Firstly, a desire to review the action in relation to the Policy which had

taken place in the four years since it had been adopted, and to update the Policy and the priorities for action in the light of this action. Secondly, and again due to local government reorganisation, there was a desire to 're-sell' the Policy to the new configuration of partner agencies, and to ensure the continued adoption and implementation by the agencies. Changes had also been on-going within Greater Glasgow Health Board since the launch of the first Policy, as a result of the restructuring of the NHS with the purchaser/provider split and the continued development of NHS Trusts. As will be further discussed within Chapter 4 problems had been encountered in engaging the Trusts to work on the Policy, and so the updating of the Policy was again seen as a means of engaging the Trusts on a more formal basis. As a result Phase 2 of the Glasgow Women's Health Policy was launched in October 1996.

In the light of these changes encountered during the first year of the research, it was decided that the research should perform a retrospective analysis of the first phase of the Women's Health Policy and the Glasgow Healthy Cities Project partner agencies prior to local government reorganisation. The decision was based on the fact that an analysis of the first stage had to be performed in order to understand the processes which had led to the development of a second phase and the contemporary action. The decision to exclude the second phase was based on the pragmatic realisation that the new organisation was at such an early phase of development that research would not be meaningful, and the quest to define the boundaries of the analysis, in order to make the project researchable.

Through a process of 'progressive focusing' the concern of the research narrowed to centre on the implementation of the Policy by and through the WHWG and the statutory sector organisations. As the research progressed, substantial differences in the involvement of each of these sectors in the implementation of the Policy emerged. The Women's Health Working Group had secured little by way of community sector representation, and voluntary sector representation came from a wide variety of organisations, but without the consistency of attendance or level of involvement of the statutory sector representatives. An additional issue was the absence of implementation structures within the voluntary and university sectors through which the implementation process could be analysed. In contrast, as joint funding partners of the Glasgow Healthy Cities Project, the three statutory

agencies were more closely engaged with both the Healthy Cities Project and the Women's Health Policy. Structures had been established within each of these organisations to oversee the implementation of the Policy, which enabled a greater depth of analysis of the process of implementation and the development of action within and between these organisations. As a retrospective analysis, the availability of documentary supporting evidence in the form of minutes of meetings and progress reports provided an important source of information for the statutory sector fora which was not available for the other sectors. This is not to say that the Policy has not been influential or implemented within the other sectors; however, in the absence of structures the analysis of this process was less accessible.

3.6 Summary of methods

Three primary methods were employed in the execution of the research, each taking place contemporaneously throughout the research: semi-structured interviews, documentary analysis and observation. Each of these methods and their conduct will be discussed in turn.

3.6.1 Interviews

3.6.1.1 Objective

Qualitative interviews formed the main element of the data collection. The interviews were semi-structured to ensure that all relevant research questions are answered, whilst retaining the flexibility to allow new ideas and information to enter the research. Using the outline of the case-study research method as outlined by Yin (1989) the interviews were intended to be both *descriptive* and *exploratory*. There were two primary objectives: to gain contextual information about the development of the WHWG and the WHP, and the organisations involved in the implementation of the Policy; and to gather the interviewees' perceptions relating to the research questions as to what had happened or not happened, and why they thought this was so.

3.6.1.2 Gaining access and sampling

Sampling

This research used a variety of non-probability techniques in defining the study sample. A combination of judgement, opportunistic and snowballing strategies were employed.

Judgement sampling involves selecting informants for the study *"according to a number of criteria established by the researcher such as their status (age, sex and occupation) or previous experience that endows them with special knowledge"* (Burgess 1984:55).

Opportunistic sampling involves the researcher selecting *"individuals who are available and who are willing to co-operate with the research"* (1984:55). Snowball sampling refers to a process which *"involves using a small group of informants who are asked to put the researcher in touch with their friends who are subsequently interviewed"* (Burgess 1984:55).

Non-probability sampling has been argued to increase the possibility of bias through the researcher selecting those they consider appropriate to research. There is also no way of determining the degree to which those researched represent the views of the population to which they belong, which may compromise the reliability and validity of the research. However, the research still has the potential of developing understandings without the claim to be representative, and the use of a multiple method approach, as in this research, enables assessment of validity through triangulation.

Defining the sample

The interviews took place in four stages. The first stage took the form of 'pilot' interviews at an early stage in the research process. Ten interviews took place between March and May 1996 which formed both a judgement and opportunistic sample: judgement because the interviewees were selected on the basis of their close involvement with the Women's Health Working Group and the Women's Health Policy; and opportunistic because their early execution stemmed from the imminent departure of many, particularly Strathclyde Regional Council, members from their organisations and the Women's Health Working Group.

The second stage of interviewing comprised of a judgement sample of three 'organisational' interviews with a key informant from each of the statutory partner agencies. These took place in August and September 1996. They were conducted in order to obtain specific information regarding the internal departmental and political/executive structures of the organisations, to identify key personnel and the availability of data for

documentary analysis. These interviews provided a contextual understanding but have not been included within the analysis.

The third stage of interviews comprised the remaining interviews with Women's Health Working Group members alongside members of the women's fora within each of the organisations. These interviews took place between November 1996 and May 1997. The sampling took place after documentary analysis of the minutes of the Women's Health Working Group and other women's fora, which enabled a judgement sample to be drawn based on attendance at meetings and involvement in the work of the groups.

During this stage it was decided to narrow the focus of the analysis to key departments within the organisations. The statutory agencies were all large and functionally differentiated organisations; as such, in order to analyse the processes in more depth it was considered necessary to select a smaller group of sections rather than to try and analyse the organisations as a whole. Within Glasgow District Council and Strathclyde Regional Council, four departments in each were selected as 'case-studies': two with a service delivery function and two dealing with corporate or internal affairs. In each case the representative on the women's organisational fora was sought to be interviewed, in addition to senior personal, in particular the directors of those departments. Councillors holding strategic positions within their organisations, such as the conveners of key committees or the leaders of the Council were also sought to be interviewed, in addition to the Chief Executive of the organisations. The Glasgow District Council sample also contained several members of the Glasgow Healthy City Project office.

Within Greater Glasgow Health Board a similar sampling strategy took place. Three directorates were chosen as a result of documentary analysis of attendance at meetings and involvement with the Women's Health Policy. Representatives on the organisational women's fora and senior representatives within the chosen directorates were sought for interviews as was the Chief Executive and key non-executive directors of the Board. NHS Trusts, although independent of the Board, were included as part of this sample due to their relationship as the providers of services and involvement in Health Board structures. Several Trust representatives to the GGHB Women's Health Policy Working Group were

interviewed within this sample, with the intention of selecting one Trust to develop as a further case-study. However, the Trusts differed widely in their size, scope and remits, making it difficult to select just one, and as a result of the interviews with Trust representatives it became apparent that action within the Trusts was not at a sufficient level to make comparative analysis of the implementation process meaningful.

In Stage Three of the interviews the majority took the form of a judgement sample. However 'snowballing' was also employed as interviewees were asked to identify key people who had been involved in the fora, with the implementation of the Women's Health Policy or who held strategic positions within their organisations.

The fourth stage of interviews involved key strategic people within the organisations and departments who had no direct involvement with the fora relating to the Women's Health Policy. These interviewees were mostly directors or senior representatives within the organisations, with the intention of gaining an understanding of the support or awareness of the Women's Health Policy at different levels, and of the perceptions of the Policy and its implementation at a senior level within the organisations. Sampling was again a mixture of judgement and opportunistic. These interviews took place between September and November 1997.

In total 65 semi-structured in-depth interviews were conducted, of which 57 were included as interview data for analysis, those omitted being the organisational background interviews, universities and voluntary sector interviews for the reasons outlined in the previous section. Of the 57 interviews, 42 of the sample were women, with 15 male interviewees. The following table gives a breakdown of the number of interviewees from each of the organisation, including their membership of the Women's Health Working Group or other women's fora and their status within the organisation.

Table 3.1: Interview sample - fora membership and organisational position.

CHARACTERISTICS	ORGANISATION		
	GDC	GGHB	SRC
WHWG	6	7	8
Women's Fora	5	16	9
HCP	5	3	2
Officer	0	0	1
Middle level	8	7	6
Senior level	4	10	6
Director	3	3	2
Councillor	2	0	5
TOTAL	17	20	20

Gaining access

In the majority of cases, access to the interviewees was undoubtedly facilitated by being a 'known face', due to my regular attendance at meetings of both the Women's Health Working Group and the GGHG Women's Health Policy Working Group, as will be discussed in the later section on observation. In addition both academic and non-academic supervisors were members of the Women's Health Working Group and having their names attached to the research 'opened doors' in many places.

In the majority of cases the interviews requested were eventually granted. However, in a substantial minority of cases, despite several attempts, interviews failed to be secured. Problems in gaining access occurred particularly within one organisation, Glasgow District Council. Five requests for interviews with women who had been the departmental representatives to the Working Group on Women's Health Policy were denied, including one with what could be described as *the* key informant, the former Women's Officer. Reasons given for their refusal to take part generally centred on the fact that many had changed posts and as such, had not been involved for sometime. As a result some felt that it would take too much time for them to re-familiarise themselves with the issues.

In addition, I was unable to secure an interview with the director of one of the GDC departments selected, or with three councillors who had a close involvement with the Working Group on Women's Health Policy or the Women's Committee. The GDC

Director delegated a former Strathclyde Regional Council employee to take his place. Two councillors refused by letter, one feeling that they had not been sufficiently involved and the other that they did not support such committees although they were a 'strong believer in sex equality'. Obtaining interviews from councillors at this time was not aided by a feeling of caution due to the political investigations that had begun during the period over the 'votes for junkets' scandal.

Interviews with Glasgow District Council representatives took the longest time to secure, particularly with senior members. When contact was finally made it became apparent that the letters sent were delegated to someone further down the organisation who had then failed to respond. In at least three cases it transpired that the letter had been passed to the same person, a key informant within the Town Clerks Office. On other occasions I was latter told that this same informant had been asked to brief senior members on the Women's Health Policy before the interview was held. Table 3.2 summarises the composition of the sample within Glasgow District Council in terms of the councillors and departments selected as 'case-studies'.

Table 3.2: GDC Sample

	GLASGOW DISTRICT COUNCIL				
SECTION	Housing	Parks & Rec.	Personnel	Town Clerk's	Councillors
NUMBER	3	2	2	8 (3 GHCP)	2

Gaining access to Strathclyde Regional Council representatives was primarily hindered by a few key informants retiring or leaving the area to pursue work elsewhere. Three requests for interviews were declined, one by a director of one of the selected departments who felt they were too busy to participate but who nominated a deputy who was subsequently interviewed. Table 3.3 summarises the composition of the sample within Strathclyde Regional Council in terms of the councillors and departments selected as 'case-studies'.

Table 3.3: SRC sample.

	STRATHCLYDE REGIONAL COUNCIL				
SECTION	Education	Social Work	Personnel	Chief Exec's	Councillors
NUMBER	4	6	2	3	5

Greater Glasgow Health Board proved to be the easiest organisation to access at all levels. The majority of interviews requested were granted. However, interviews were not secured with non-executive directors of the Board. Two people had been selected due to their senior position and close involvement with the Healthy Cities Project, but they had both previously left the Board and declined to be interviewed. A change in senior membership of the Board meant that existing members associated with Healthy Cities Project or Women's Health Policy had not been involved in the period under review and therefore were not suitable candidates for interview. Although this presented a problem, a few executive directors of the Board were interviewed as part of the broader sample. Table 3.4 summarises the composition of the sample within Greater Glasgow Health Board in terms of the sections selected as 'case-studies'. 'Other' refers to a Local Health Council representative.

Table 3.4: GGHB sample.

	GREATER GLASGOW HEALTH BOARD					
SECTION	Public H	Health P	Trusts	Commiss.	Exec.	Other
NUMBER	3	4	9	2	1	1

3.6.1.3 Approach

Due to the exploratory nature of the fieldwork, semi-structured qualitative interviews were chosen as the most appropriate methods. The interview consisted of a range of topics emerging from the research questions and literature which appealed as 'puzzlements' (Lofland 1971). A topic guide was developed based on the research questions, with questions grouped in a number of broad categories:

- **Background** - employment background; involvement with GHCP/ WHWG/ organisation women's fora.

- **Health** - concept of health, women's health, and perception of health within department/organisation.
- **Women's Health Working Group/ Organisational women's fora** -involvement and perception of the role, strengths and weaknesses of the Groups.
- **Women's Health Policy** - perceptions of the Policy, its purpose, necessity, objectives, strengths, weaknesses and successes.
- **Organisation** - perception of role and importance of health in their organisation/department, changes occurring in their organisation as a result of implementation of Policy, interaction/communication with the WHWG.
- **Implementation** - perceptions of how organisation had attempted to implement the policy, the extent to which they considered the policy objectives/targets to have been implemented, enablers and barriers to implementation.
- **Multi-agency working** - definitions, examples, advantages and disadvantages, enablers and obstacles to multi-agency working.
- **Changes?** - improvements that could be made to WHWG, WHP, implementation, and multi-agency working.

3.6.1.4 Designing the topic guide

The topic guide was devised at a relatively early stage in the research, due to the need to begin the fieldwork prior to local government reorganisation. This was due to the fact that several key informants were leaving their existing employment, with some people moving cities and even abroad. As such the questions were devised before a substantial amount of the literature review had been conducted. This is reflected in the breadth of the questions. Being semi-structured the guide ensured that the core areas of information were gathered but also allowed for a flexibility in the questioning so that new areas of interest and information could be included. Some structure was necessitated by the large amount of information it was hoped to gather from people, and the desire to have a comparable range of information across all the interviews. It was intended that each of these areas should be covered in the interviews but to a degree the topic guides were tailored in accordance with the individuals' organisation, field and experience. A copy of the topic guide can be found in Appendix 2.

In relation to the particular questions contained within the topic guide, I began with a range of background, contextual questions concerning the interviewees' professional background, and their involvement with the WHP, the WHWG or the various organisational women's fora. These questions were intended to identify the length and level of their involvement with the WHP.

Whilst some areas of the topic guide more obviously point to one of the research aims more than another, each are relevant to all of them. One aspect of the WHP that interested me was the social model of health incorporated within it. Due to the popular conflation of health with ill-health, I was interested in the interviewees' concepts of health and women's health, and the factors which affect peoples' health. I was also interested in their perceptions of the centrality of health to the operation of their organisation. These questions were selected to ascertain whether the meaning attached to the word 'health' and its level of importance within an organisation would impact on the level and direction of the implementation of the WHP.

Questions relating to the WHP, its content and purpose were asked primarily in order not to take for granted what was, for them, the intention and focus of the Policy. This again links back to the model of health incorporated within the Policy and its divergence from much of the contemporary health policy. I was interested in the extent to which socially constructed gender roles were inferred or challenged within both the discussions of the WHP and of women's health. One specific question asked concerned whether the interviewees considered there was a need for a separate women's health policy. This was deliberately included, firstly so as not to presume support, secondly to enable the interviewee to challenge the notion, and also because of an awareness that in such a subject area there may be a danger of obtaining a 'politically correct' response. This question proved to be very illuminating.

As has previously been identified, much of the work connected to the WHP took place within the WHWG or organisational women's fora. As such the perceptions of the interviewees as to the role, direction and strengths and weaknesses of these groups were seen as vital to understanding the form the implementation took within these organisations.

These questions were broadened beyond the specific fora, to look at how the interviewees considered the WHP to have been implemented within their department or organisation generally. This was to ascertain any potential examples of changes that had taken place and the reasons or processes connected to such events.

Questions connected to multi-agency working were invariably left to the end of the interview. Whilst the interviewees were aware of my interest in multi-agency working, specific questioning on the topic was kept within a separate section for two reasons. First, so as not to presume that multi-agency working was necessarily part of the interviewees' experience of the implementation of the policy. Interviewees were able to highlight its relevance in various parts of the interview, if that was their experience. Second, this section was designed to place discussion of multi-agency working in a more abstract context, exploring what they understood of the term 'multi-agency working' and what they considered the strengths and weaknesses, enablers and barriers to this approach to be. This section was added after the pilot stage of the interviewees largely because of the failure of any discussion of multi-agency working to arise within discussions of the implementation of the WHP.

Finally, the topic guide ended with a series of questions concerning potential changes that the interviewees considered would act as improvements to the issues discussed. These questions were included both to enable the interviewees to reflect on the discussion and potential ways forward, and also to provoke thought on the present situation.

Following Spradley (1979) the questions were a mixture of 'grand-tour' questions and 'floating' prompts. The questions were deliberately open-ended, allowing the interviewee the flexibility of interpretation. A number of prompts were used so that if the desired information was not being elicited a new line of questioning was attempted. On some occasions repeated questions were used as a means of ensuring that the correct interpretation had been made. Probing was frequently used to elicit further information and to gain examples to demonstrate the arguments presented.

Although several ideas emerged prior to and during the course of the fieldwork, the questions remained open and abstract. For example although 'gender' was considered to be a key issue, questions regarding 'gender' were not asked directly so as not to prejudice the issues that emerged within the interview. Rather 'gender' was reserved as a probe and explored once the issue emerged. Other strategies were employed during the interviews to try and ensure the fidelity of the interviewees responses.

3.6.1.5 Conducting the Interviews

The vast majority of the interviews took place in the interviewees' own offices. All of the interviewees had been approached through an initial letter explaining the nature and aims of the research. At the beginning of each interview I introduced myself and restated the broad area of my research. I emphasised that it was their experiences and perceptions I was interested in, and assured the interviewees that the interview data would remain confidential and any information used would not be attributable to them. I asked the interviewees to be as honest as possible and to ask if they were not clear about the meaning of any of the questions.

The interviews were intended to take between 40 and 50 minutes. In reality, they lasted anything between 20 minutes and two hours. All of the interviews were tape recorded, transcribed verbatim and coded using the NUD*IST qualitative analysis package. The resulting transcripts were used as the major source of data in the analysis.

3.6.1.6 Fieldnotes

Throughout the developmental, field work and analysis stages of this research fieldnotes were taken, documenting the processes and experiences of research. Field notes are important so that the reader can "*compare the data gathered with the inferences that are made*" (Burgess 1982 : 191). Due to time constraints, the fieldnotes were used largely for reference and were not systematically recorded in the ways suggested by Lofland (1971). However, these fieldnotes proved vital in the later stages and writing up of the research, enabling me to recall distant events, compare the interview transcripts to the impressions on the day, and see the development of ideas.

3.6.1.7 Objectives achieved?

The interviews in the main proved very successful and provided a wealth of contextual information as well as data relating to the research questions. As a retrospective study, using a multiple method approach was important in gaining supporting information for some of the issues raised, as will be discussed in later sections.

3.6.1.8 Practical issues

The primary issue during the interview process was the difficulty experienced in gaining interviews, particularly with senior personnel and councillors, and within GDC. These difficulties have been detailed within the sampling section, and are considered to be significant supporting evidence to issues raised within subsequent chapters concerning the perception of some interviewees of the marginalisation and lack of organisational support in relation to the implementation of the Policy. Local government reorganisation may also have had a bearing on the reluctance of some people to be interviewed, particularly where the nature of their employment had changed. A possible alternative to the approach taken of contacting the individuals directly would have been to request support for the research from the top of the organisation, as recommended by Crompton and Jones (1988). However the level of 'subversion of aims' and departmentalism raised by interviewees in relation to the organisations leads me to query whether this approach would have been any more successful.

My experiences of conducting some of the interviews with senior, particularly male representatives within the organisations were, on occasion, unpleasant. Some tended to be dismissive of the research and its subject. At the time I attributed some of this to the topic of the research and a defensive response due perhaps to their limited knowledge of the area. For example, one interviewee constantly referred me to policy documents I knew to be inappropriate to find the answers to questions I was asking. However, as my subsequent research experience in other subject areas suggests, this response was also a result of the perceived lack of status of myself and my work, largely due to my being a young female researcher.

At first glance the ethical issues raised by this research appear to be minimal. The interviewees were all approached individually, to be interviewed in their professional capacity, and gave their informed consent to be interviewed and have the resulting information written up as part of PhD research. Interviewees were all guaranteed that the information would remain anonymous and confidential. However, on reflection, as the research is based on a single case-study containing a tight knit policy community, it raises questions as to the extent of anonymity possible. Whilst many interviewees said they were not bothered about the confidentiality of the information, it does raise questions about the naming of actual case-studies. However, to not name a case-study would make the presentation of background contextual information more difficult, and the results non-verifiable by other researchers. This problem has been overcome by identifying interviewees numerically by organisation.

Despite these difficulties, in taking a flexible approach to identifying alternatives, it is felt that the appropriate level of representation was gained within each of the organisations.

3.6.2 Documentary analysis

3.6.2.1 Objective

Documentary analysis formed the second major research method used within this research. As part of a retrospective analysis the role of the documentary analysis was to provide evidence of the process of implementation of within the partner agencies. It was intended to provide a descriptive context to the study, reviewing the priorities established, the issues addressed, and the action taken within the Women's Health Working Group and the other organisational fora. It was also intended to act as supporting evidence to the perceptions of the interviewees with regards to that process, and was used as a means of gaining a judgement sample for the interviews.

3.6.2.2 Types of documents

A number of distinctions can be made between types of documents: they can be primary or secondary sources; primary sources can be deliberate or inadvertent; and documents can contain witting or unwitting evidence (Duffy 1993). As several authors have noted

documents and their archives are socially constructed, and important questions need to be asked of the data available. As Macdonald and Tipton note

the mere fact that a document has survived for the researcher to read means that in addition to the decision to produce the record in the first place, someone has decided to keep it, possibly deciding at the same time not to keep others, to store it in a particular archive, in a particular order ... a set of minutes, the accounts of a public company, or official statistics are produced in a socially acceptable form that seems to those involved to give a 'reasonable' account of their actions.
(1993:188-189)

The advantages of documentary analysis include: gathering information on groups or topics unavailable elsewhere or on events or groups too small, too scattered or too difficult to trace (Hakim 1987); that the data is 'non-reactive' therefore less subject to interviewer bias, and that data is frequently available for longer periods of time than can be researched through other methods, which is particularly useful in the analysis of change within organisations (Bryman 1989); and that they are available and often more accessible than other forms of data (Silverman 1993).

However there are also a number of drawbacks to documentary analysis, not least that it tends to be time-consuming. The researcher is often frequently constrained by the availability of data, which may be incomplete or not accessible due to issues of confidentiality. As the majority of documents are produced for a purpose other than research the categories used and the data contained may not be suitable for the desired use. In addition, some authors question the accuracy that can be assumed. Gottschalk *et al.*, (1945) suggest the following questions should be addressed:

- 1) *Was the ultimate source of the detail (the primary witness) able to tell the truth?*
 - 2) *Was the primary witness willing to tell the truth?*
 - 3) *Is the primary witness accurately reported with regard to the detail under examination?*
 - 4) *Is there any external corroboration of the detail under examination?*
- (Gottschalk, Kluckholm and Angell (1945:35)

The documentary analysis within this research has drawn on the primary and inadvertent source material of official organisational reports and minutes; inadvertent because it was produced as a public account of the actions of organisations rather than for the purposes of research.

3.6.2.3 Gaining access and sampling

Sampling

Through the organisational interviews and continued familiarisation with the field, information was gathered relating to the structures of the organisations and the relevant fora and departments through which to gather documents relating to the decision-making and implementation process. Four main sources of data were used in the documentary analysis: the reports and minutes of the Women's Health Working Group; the GGHB Women's Health Policy Working Group; the SRC Advisory Group on Women's Issues and Health Issues Based Group; and the GDC Working Group on Women's Health Policy and Women's Committee. In addition the Council Minutes for GDC and SRC, and the GGHB Board Papers were also reviewed for information relating to the Women's Health Policy or the work of the various fora. The entire available record of the four main data sources were reviewed alongside the Board or Council minutes for the same period. For GDC and GGHB the period covered was 1992-1996 (GDC Women's Committee 1994-1996), for the Women's Health Working Group 1990-1996, and for Strathclyde Regional Council 1988-1996. A longer period was reviewed in the latter case due to the existence of the relevant fora, the Advisory Group on Women's Issues, prior to the development and implementation of the Women's Health Policy. The intention here was to research the changes that had taken place in the focus of the Group since the adoption of the Policy.

Gaining access

The minutes of the Women's Health Working Group were obtained through my supervisors. These records were incomplete for the years 1990-1993. The minutes of the GGHB Women's Health Policy Working Group and GGHB Board papers, and the minutes of the GDC Working Group on Women's Health Policy were both obtained through key informants within the respective organisations, whilst SRC documents were obtained through a reference library. All of these records were more or less complete.

3.6.2.4 Approach

Three forms of qualitative documentary analysis have been identified by Silverman (1993): ethnographic, semiotic and ethnomethodology. The documents in this research form an

ethnographic analysis, which “*seeks to understand the organisation of social action in particular settings*” (1993:60).

Two main strategies were employed in the analysis: identification of representatives in order to trace the involvement of individuals and departments in the fora throughout the period, and also to make a judgement sample for the Stage 3 of interviews. Secondly the minutes were reviewed for themes and issues emerging and decisions made, from which working papers were produced for later analysis. These papers contained: a descriptive account of the structures and groups within each of the organisations, a review of the processes by which the Policy had been introduced, adopted and addressed; an analysis of the strategies employed to implement the Policy, the issues and objectives identified, what action had taken place; and a review of multi-agency initiatives.

3.6.2.5 Objectives achieved?

The documentary analysis was successful on a number of fronts. It provided a descriptive context to the events and debates that had taken during the period under review, and supporting evidence to many of the issues that had been raised during the interviews. It additionally enabled the identification of the key players in the fora and led to the identification of potential interviewees. It also provided additional information on the structures that existed within the organisations, and illuminating insights as to just how marginal the women’s structures were within Glasgow District Council and Strathclyde Regional Council in particular. Rarely were women’s issues raised through the intended committee structure, which undoubtedly limited the extent of dissemination. This reflects comments made by a number of interviewees on the status of women’s fora and women’s issues within their organisations, as is discussed within subsequent chapters.

3.6.2.6 Practical Issues

Documentary analysis is extremely time-consuming and laborious. There is also the issue of the official language and format of much of the data which required understanding and interpretation. As official records they cannot be taken at face value as an accurate representation of the full discussion that may have taken place at the meeting, but the

official edited version. However, as part of a retrospective analysis, the data provided was invaluable.

3.6.3 Observation

3.6.3.1 Objective

Observation constitutes the third method employed within this research. The objective of using observation was to study the agencies involved in the implementation of the Women's Health Policy and the process of implementation within these organisations. In addition it was intended to analyse the dynamics of the various fora, to study the processes by which decisions were made, action taken, and the enablers and barriers to that process. Through using observation in addition to other research methods it was also hoped to add to the validity of the findings.

3.6.3.2 Types of observation

Observation is considered an important method for revealing characteristics unobtainable by other means, as direct observation may be more reliable than what people say. Robson (1993) argues that “*direct observation in the field permits a lack of artificiality which is all too rare with other techniques*”. (1993:191). Bell (1993) suggests that unstructured observation is useful in generating hypothesis, an important element in qualitative research.

There are a variety of ways in which observation can be conducted. Two main distinctions are between covert and overt observation, and participant and non-participant observation. These distinctions are polarities and in reality observation often involves their differing use within different aspects and circumstances. Gold (1958) distinguishes four different ‘ideal type’ observer roles:

- complete participant - always working in setting, observer role concealed
- participant as observer - working but with distinct periods of unconcealed observation
- observer as participant - mainly observing but occasionally participating
- complete observer

My role within this research was most closely aligned to that of 'observer as participant'. As I was not a member of any of the fora I attended my primary role was as an observer, participating very rarely within meetings except when asked to do so. However over time the number of informal exchanges during and after meetings increased, leading to me no longer being just an observer.

Observation requires the close involvement of the researcher as an instrument in the research. As such a number of problems can be encountered in the process of data collection and analysis. A methodological disadvantage is that observation can be very time-consuming and demanding. Many authors point to the danger of bias in data collection and analysis. Robson (1993) notes the danger of selective attention resulting from personal experience, interests and expectations which may unconsciously restrict observations; and interpersonal factors as focusing on particular group members may lead to bias. There is also the question of the generalisability of the research findings which concentrate on certain groups. However the aim of much qualitative research is to develop understandings of social processes rather than concrete social facts, and such detailed work can produce valuable information and insights.

The problems listed above are criticisms common to qualitative research and other research techniques such as interviewing. However, it is argued that by being aware of the potential problems, their effects can be minimised.

3.6.3.3 Gaining access and sampling

Choosing appropriate settings and negotiating gatekeepers are one of the first considerations in conducting observations. Access and situations will be determined by the research questions and the origin of the study, whether it is opportunistic or commissioned (Adler & Adler 1994). In deciding to conduct observation a number of factors have to be taken into consideration: simplicity, accessibility, unobtrusiveness, permissibility, frequency of occurrence, and participation.

Sampling

In conducting the observation I was constrained by the availability of settings in which observation could take place. Although a Women's Health Co-ordinator had been appointed by Greater Glasgow Health Board within whose remit it was to oversee the implementation of the Women's Health Policy within the Health Board, no comparable post had been created within the other two organisations. In addition due to the way in which the work on the Women's Health Policy was developed there were no identifiable areas outwith the established fora in which work on the Policy could be observed. Thus observation was limited to meetings of the Women's Health Working Group and other organisational fora established in relation to the Women's Health Policy.

Further, as the research focus narrowed and became retrospective, the role that observation could play within the research became more limited. The SRC Advisory Group on Women's Issues had ceased to meet prior to the research commencing. In addition the GDC Working Group on Women's Health Policy had practically ceased to function since the establishment of the Women's Committee in 1994, evolving into a project based group overseeing the development of the Women's Health Policy Fair held on International Women's Day, March 1996.

However the two remaining groups, the Women's Health Working Group and the GGHB Women's Health Policy Working Group were used as sites of observation which I attended regularly as an observer. Following the establishment of the Equality Committee within the new Glasgow City Council, attendance of these meetings also took place.

Gaining access

To a large degree the issue of access was circumvented due to the origin of the research in collaboration with one of the GHCP statutory partner agencies - Greater Glasgow Health Board. Access to the Women's Health Working Group and GGHB Women's Health Policy Working Group was obtained through my supervisors, whilst the Equality Committee was open to the public to observe.

3.6.3.4 Approach

In relation to conducting observation, Robson (1993) distinguishes between informal and formal information gathering approaches. He defines informal approaches as being less structured and more flexible as to what information is gathered and how it is recorded, usually by note-taking and diary-keeping. This approach is more complex and time-consuming but may lead to a more complete analysis. Formal approaches are more structured and directed as to what is observed, only noting pre-identified aspects, and higher reliability and validity are gained at the expense of complexity and comprehensiveness. Within this research, the approach to observation changed from informal to formal with increased familiarity with the field.

The observation was at first largely exploratory and descriptive, establishing who is involved in the various groups, the work conducted and the issues raised. This later developed into a more systematic analysis of these meetings in relation to the research questions. The observations, although remaining flexible, sought to identify the key actors at meetings - those actively participating and taking on work, the content of debates and decisions taken. Notes were taken at the meetings, concentrating on the speakers and the issues under discussion. Included within this, though highlighted as distinct, were my impressions of the meetings and any areas of interest I wanted to follow up.

In the Women's Health Working Group and GGHB Women's Health Policy Working Group meetings my presence was known to the members as being to observe as part of my research. At both of these meetings a round of introductions at the beginning of the meeting ensured that everyone present was aware of my status. There was no such means of making myself known to the Equality Committee and as such they were unaware of the reason for my attendance.

3.6.3.5 Objectives achieved?

Due to the limited situations in which observations could occur the level to which the organisations and implementation processes could be observed was limited. In addition, the retrospective focus and the fact that two of the four fora identified no longer existed meant that the extent of observation was limited. The Equality Committee proved to be a

restricted venue for observation as it lasted on average 30 minutes and was purely a business meeting at which councillors passed or rejected issues or documents with little debate or discussion. I stopped attending these meetings after a period of six months although I continued to receive the committee minutes. Observation at the other two fora continued until February 1998. Whilst the observations took place outside the period of analysis rendering the content of the meetings of little value, it is believed that the processes observed can be taken as representative of the processes and dynamics existent within the groups prior to the reorganisation.

3.6.3.6 Practical Issues

This was the least satisfactory out of all the methods employed. The main reason for this was the changing focus of the research to become a retrospective analysis, and thus the short period and limited access during the period under analysis. The observational data will have minimal inclusion in the thesis but was valuable in the wealth of understanding obtained. As a method it was also extremely time consuming both in terms of data collection and analysis.

3.7 Analysis of Data

To a degree, analysis was an ongoing process throughout the period of research, as themes and issues were identified at various stages through the interview data and documentary analysis. Full verbatim transcripts were made of the interview data which were analysed using the NUD*IST qualitative data analysis package. The field notes from the observations were assembled and prepared for analysis, as were the working papers produced on the documentary analysis. The data were analysed in a manner approximating Strauss (1987), with initial 'open-coding', their development into 'axial-codes', and the search for a 'core category'.

'Open-coding' refers to the initial unrestricted, often provisional coding of the data, whereby the interview is closely scrutinised to "*produce concepts that seem to fit the data*" (Strauss 1987:28). Through this stage of coding, Strauss argues, the researcher begins to ask questions of the data, and to think conceptually rather than literally in terms of relationships within the data. 'Axial-coding' involves the "*intense analysis done*

around one category at a time", resulting in *"cumulative knowledge about relationships between that category and other categories and sub-categories"* (Strauss 1987:32). Axial coding takes place before the researcher becomes committed to a core category as it *"within this increasingly dense texture of conceptualisation, linkages are ... made with the category, or categories, that eventually will be chosen as the 'core'"* (1987:32-33). Strauss refers to a third stage of 'selective coding': *"coding systematically and concertededly for the core category."* (1987:33).

As Wolcott (1990) has noted, one of the problems associated with qualitative analysis is the breadth of the data obtained. As such a process of 'winnowing out' or whittling down was undertaken to draw out that information most relevant to the research objectives. At the preliminary coding stage, attempts were made to distinguish different elements in the transcripts. The axial codes develop the initial coding, drawing links and trying to identify themes within the transcripts. The themes are then compared to those found in the literature review in a process of 'pattern-matching' (Yin 1989).

NUD*IST proved to be an invaluable tool for managing vast quantities of qualitative data, and enabling the documents to be search and re-searched, coded and re-coded over a period of time. In the writing of the thesis quotations from the interview transcripts were selected to represent the themes and issues emerging. Attempts were made, as far as possible to quote from a range of interviewees from the three organisations, and those occupying differing positions within them.

3.7.1 Reliability and validity

Reliability and validity are important considerations in any research. A debate between the positivist and interpretivist schools of social science concerns the ability to accord scientific status to research. Positivism in its search for social facts and reality uses a model of social research based on natural science and stresses the importance of hypothesis deduction, verification and refutation. Objectivity is seen as an obtainable and desirable goal. Within the interpretivist school arguments exist as to the possibility and desirability of objectivity, with authors such as Agar (1986) suggesting the relinquishing of traditional scientific standards in favour of *"an improvisational style to meet situations not of the*

researcher's making, and an ability to learn from a long series of mistakes.” (1986:12).

Others argue that although the model of natural science is inappropriate for the study of social life and interaction, objectivity is still an important goal and claims can still be made for the scientific nature of qualitative methods. As Silverman (1993) notes,

It is an increasingly accepted view that work becomes scientific by adopting methods of study appropriate to the subject matter. Sociology is thus scientific to the extent that it uses appropriate methods and is rigorous, critical and objective in its handling of data. (1993:144)

Two key features needed to assess the objectivity of the research are reliability and validity.

According to Kirk and Miller, “*‘reliability’ is the extent to which a measurement procedure yields the same answer however and whenever it is carried out*” (1986:19) and thus refers to the degree of replicability of the research. Kirk and Miller distinguish three types of reliability: quixotic reliability, which refers to the “*circumstances in which a single method of observation continually yields an unvarying measurement*” (1986:41); diachronic reliability which refers to “*the stability of the observation through time*” (1986:42); and synchronic reliability, which refers to “*the similarity of observations within the same time period*” (1986:42).

In order to demonstrate the reliability of the research, the researcher must document the research procedure “*at such a level of abstraction that the loci of decisions internal to the research project are made apparent*” (Kirk and Miller 1986:72). This has been the intention of this chapter.

According to Kirk and Miller, “*validity is the degree to which the finding is interpreted in the correct way*” (1986:20). They distinguish between three different types : apparent, which is the most basic form and refers to things ‘seeming’ valid; instrumental validity, which refers to situations where it can be “*shown that observations match those generated by an alternative procedure which is itself accepted as valid*” (1986:22); and theoretical or construct validity which exists where “*there is substantial evidence that the theoretical paradigm rightly corresponds to the observations*” (1986:22). Two common approaches to assessing the validity of research are triangulation, in which alternative research methods

are used to see if different methods produce the same results, and respondent validation, where the findings are reviewed by those interviewed.

Triangulation was used in the design and execution of this study. Documentary analysis supported the accounts of interviewees, and observation, although limited, reflected the perceived dynamics, enablers and barriers highlighted. The value of respondent validation, it may be argued, is debatable as the conceptualising of data resulting from the analysis may not be understood or fit with the respondents' own interpretations. As Fielding and Fielding (1986) note,

there is no reason to assume that members have a privileged status as commentators on their actions ... such feedback cannot be taken as direct validation or refutation of the observer's inferences (1986:43)

3.8 The Research Experience

At the beginning of this chapter I highlighted the origins of this research with people who were closely involved with the subject of this research, and its status as a CASE studentship. These aspects have undoubtedly impacted to some extent on the design of the research, as I have sought to illustrate. They have also had an impact on my experience of conducting the research. In this final section I will reflect briefly on some of these aspects.

I have discussed elsewhere within this chapter some of the implications of being appointed to conduct a CASE Studentship. Many of these relate to the development of the research idea and remit prior to the involvement of the researcher. As such other interested parties have a clear idea of the research they would like to be done, and the form that they would like it to take. As with other PhDs, the research remains an individual, independent, academic project. However, where they differ, in my experience is through the process of negotiation that needs to be engaged in, particularly with the 'industrial sponsor'. This relates not just to the direction and design of the research, but on the expected outputs. On occasions I experienced divided loyalties between my aim of conducting an in-depth analysis for a PhD and my external supervisors' wishes for instant answers. This perhaps reflects the much shorter timescale generally associated with research on particular

policies. This occurred primarily with the first year of my research, a time of enormous change as far as the Policy was concerned, and one in which my external supervisor was understandably looking for some research evidence to perhaps inform changes. I too was also frustrated by this situation, and the gap between a political desire to act and my lack of involvement as a non-participant observer. However, my academic supervisor provided an important mediator between myself and my sponsor, and these concerns were largely allayed.

Whilst differences of interest between an academic and a policy audience may be common to other CASE studentships, one way in which my experience perhaps differed was in having both of my supervisors involved, to a greater or lesser extent, as subjects of my research. Having both of my PhD supervisors closely involved in the development of the WHP and the WHWG undoubtedly provided me with a range of opportunities. For example access to much of the documentary analysis was obtained through archives collected by my supervisors. In addition, access to the WHWG, various organisational fora, and to some of the interviewees may have been facilitated by their involvement.

However, this situation also presented a number of challenges. Having both supervisors involved in the WHP, they obviously had a wealth of knowledge and experience of the WHP, and their own views on the research questions. At times I felt isolated as knowing glances were exchanged as I discussed my findings. In addition, by its very subject, my research was obviously going to involve a critique of their work. As a result, whilst I did not allow it to affect the analysis, I was conscious that some of the findings may not have been welcome, and of the potential implications some of these may have for future work.

One of my main concerns surrounded the confidentiality of the interviewees. A potential conflict of interest arose as my external supervisor, who was also the Chair of the WHWG, had access to the views of the interviewees whom, whilst not named, she could possibly guess the identity of. Attempts were made to minimise this by removing any other identification than the organisation and sex, and by limiting her access to the data prior to the final drafts of the analysis. Again, however, my academic supervisor provided a valuable mediator between the academic and policy aspects of this research.

Finally, perhaps the most significant influence on my experience of conducting this research was the timing of when it started. I have previously identified the variety of changes that occurred within the first year of my research, which impacted on the decision to perform a retrospective analysis of the implementation of the WHP. However, the context of change also produced a pressure to begin the interviews with key informants at a relatively early stage within the research process, within the first six months and before a significant amount of the literature had been reviewed. Whilst this was done for very good reasons, on reflection waiting until I was more immersed in the field would perhaps have enabled me to be more focussed in my research questions rather than taking such an exploratory approach. However, this also had the advantage of not foreclosing potential areas of interest.

3.9 Summary

This chapter has outlined how the research was designed and the methods employed. It has sought to explain the choices and decisions made in selecting those methods, the samples developed and the strategies employed in executing the research. Analysis of the case-study begins within the next chapter, beginning with an exploration development of the Women's Health Policy and its implementation within the statutory partner agencies.

Chapter 4 – The Case Study: Action on Women's Health in Glasgow

4.1 Introduction

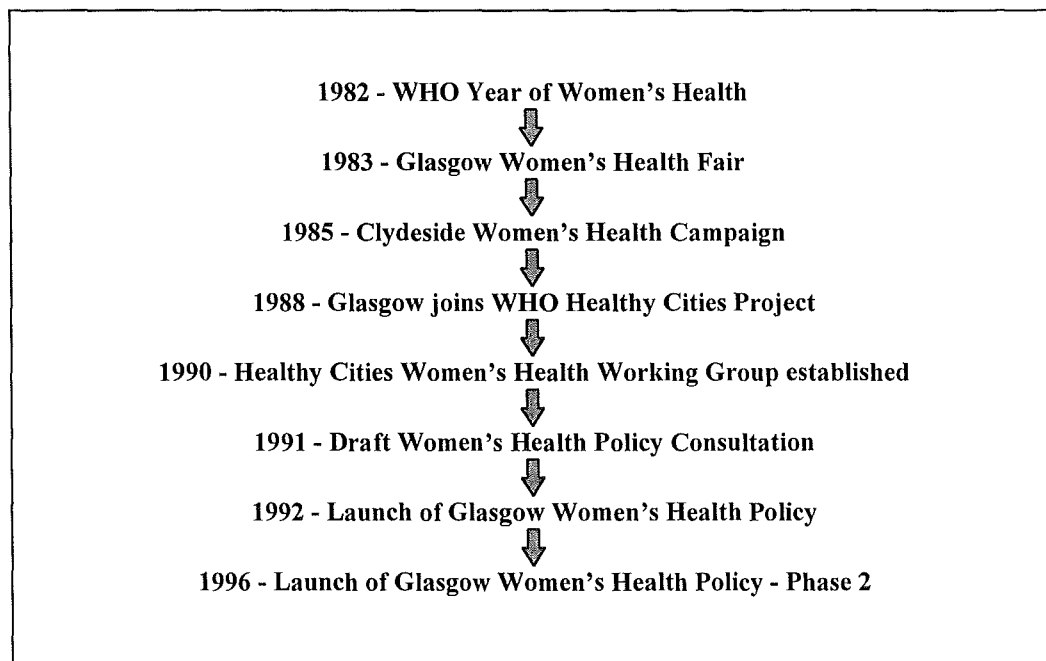
The Women's Health Policy, launched in 1992, can be seen as one example of an ongoing range of activities to promote women's health in Glasgow. As this research takes the form of a case-study, it is important to analyse the emergence of this Policy within the context of its development. This context will have informed the shape and direction of the Policy and thus will provide useful insights into the process of its implementation. This is the aim of this chapter.

The chapter begins by reviewing the background the development of action on women's health in Glasgow, including the development of the Women's Health Working Group. This is followed by a discussion of the processes associated with the development of the Women's Health Policy itself. Finally, the development of the various organisational fora established to oversee the implementation of the WHP are reviewed.

4.2 Development of action on Women's Health in Glasgow

The origins of action on women's health in Glasgow in recent years can be traced to 1982, which was designated by WHO as Year of Women's Health. During that year the WHO European Women and Health Conference was held in Peebles, Scotland, and a Scottish Women's Health Fair was subsequently organised in Edinburgh. These two events were influential in generating the impetus for a similar event to be organised in Glasgow, as will be discussed below. Figure 4.1 demonstrates the chronology of events leading to the development of the Women's Health Policy.

Figure 4.1: Key events leading to the launch of the Women's Health Policy



There has been a history of campaigns on health over the years. In 1981 the West of Scotland Politics of Health Group (WSPHG) was established in the city, which was formed in response to increasing threats to the NHS, and sought to raise awareness of the impact of poverty on health (WSPHG 1984). Several of the people who were subsequently involved in campaigning for women's health and the Glasgow Healthy City Project were members of this group.

4.2.1 Glasgow Women's Health Fair

The idea to hold a women's health fair in Glasgow was initiated by members of the Health Education Department (latterly known as the Health Promotion Department) of Greater Glasgow Health Board. As one interviewee instrumental in its development commented, the WHO conference at Peebles had been a fairly high status event and women's groups had not been invited to participate. As a result of this

initially that led to a revolt in Edinburgh where they decided that they would have an alternative event for women. Women got wind of it here in Glasgow and initially they were going to join in and contribute to that event, but then they thought 'what the hell, we should have our own', and that's how it came about. (GGHB Interviewee 9)

They sought to develop multi-disciplinary representation and involvement from women in the community, and held an open meeting in March 1983 to discuss organising a fair. Women and men from all sectors were invited to attend, and subsequently a Women's Health Fair Working Group (WHFWG) was established to oversee the organisation of the Fair.

The working group included representatives from the Health Board, SRC Social Work and Community Education Departments, the Family Planning Association, the voluntary sector and community groups. The group initially identified six factors which they considered to affect women's health: social policy; poverty; nutrition; reproduction; family relationships; and employment/ unemployment. Later a seventh theme was identified - the changing role of women - and each of these issues formed the basis for establishing a themed sub-group to develop the issue further. The subgroup meetings were held in a range of different community settings in an attempt to integrate local women. Despite this, problems were encountered in establishing representation from community groups; and also in working collaboratively, due to the diverse professional backgrounds and a lack of previous experience of doing so (WHFWG 1983:8).

The aims of the fair reflected the aims of those involved in its development. Whilst for some the aim was health promotion and education, for others the aim was to generate publicity and information on women's health, and for others to promote collaborative working between the various agencies in Glasgow. The Women's Health Fair was held over four days in October 1983, at a number of city venues. In addition to workshops on the seven themes identified, a Well Women Clinic was organised, and a crèche and exercise sessions were provided. The Fair was attended by over 6000 women, and heralded a success by the organisers. One interviewee involved on the organisation of the Fair commented,

It took on a life of its own and brought in a lot of women from different organisations to participate in the organisation of it, and it turned out to be enormously stressful, but I think pretty successful looking back on it now...It was extremely ambitious...I mean none of us had organised anything like that before. (GGHB Interviewee 4)

A series of recommendations from each of the sessions were produced which commonly reflected the need for women to have more information about the availability of services and their rights. Other issues concerned: the need to establish links with women in the community; the need for greater provision of well woman services, in all localities, with women staff and crèche facilities; and more resources allocated to the promotion of positive mental health by health and other professionals and the voluntary sector (1983: 26-27).

Significantly, at various stages within the report the authors comment on a problem in the organisation of the Fair being that managers of those participating in the organisation of the Fair were 'not always sympathetic to the Fair' (1983:8) and the restricted time availability of some people due to the lack of seconded time (1983:25). As one interviewee commented

Regional staff were involved. They actually had quite a lot of difficulty getting time off work to participate because there was an even poorer understanding then of the relationship between local authority activity and health than there is now...The District Council was very difficult to crack at the time although we did attempt it, but we didn't have involvement from any of their departments. (GGHB Interviewee 9)

This issue of a poor understanding of the role of health within organisations and the lack of senior support within the organisations is a recurring theme in this thesis and will be discussed further in subsequent chapters.

Following on from the Glasgow Women's Health Fair, further fairs were held across Scotland and groups established in different communities and agencies (WHFWG 1983:27). The success of the Fair in bringing a number of women from different backgrounds together led to the desire to see that the issues and interest raised was built upon. As one interviewee noted,

It was felt that it just couldn't end with that event, there had to be some mechanism for taking some of that forward in a way that could put some pressure on the organisations that either provided care or were in a position to affect women's lives. (GGHB Interviewee 9)

The Women's Health Fair Working Group continued to meet until, in 1985, it was reformed and re-launched as the Clydeside Women's Health Campaign.

4.2.2 Clydeside Women's Health Campaign⁴

The Clydeside Women's Health Campaign was launched in September 1985, as a campaigning group seeking to *"try to influence those who have control over the delivery of health services and also try to reach the many women who do not know of the services already available and have no access to the information they need"*⁵. Membership of the group included women from the Health Board, Local Health Councils, Strathclyde Regional Council, women's groups and the voluntary sector. The four main aims of the campaign were:

- *To promote women's health and research into women's health*
- *To expand health facilities for women including well woman services*
- *To support women's rights to choose their own medical treatment and fertility*
- *To campaign for women's rights, especially those contained within the Women's Health Charter*⁶.

The CWHC developed a Women's Health Charter which formed the basis of the groups campaigning, and consisted of the following thirteen statements:

1. *Women should have control over their own bodies*
2. *Women should have the opportunity to achieve new health potential*
3. *Women should be encouraged to take informed decisions about their own medical care*
4. *Women should have the right to all health screening procedures which will establish the early onset of disease*
5. *Women should have health counselling facilities available to them within the N.H.S.*
6. *Women should have the right to medical advice/treatment from women doctors*
7. *Women should have access to Well Woman Centres within their local area.*
8. *Well Woman Centres should cater for women from all cultural backgrounds*
9. *Ethnic Minority women should have health information available to them in first language translation.*

⁴ Information on the Clydeside Women's Health Campaign has been derived from the available reports, letters, minutes and newsletters of the Group between 1985-1991, which are incomplete, and information gathered during interviews with key informants who were involved in the campaign.

⁵ Women's Health Fair Working Group (1985) *Newsletter* (Glasgow : Women's Health Fair Working Group) pp.2

⁶ Women's Health Fair Working Group (1985) *Newsletter* (Glasgow : Women's Health Fair Working Group) pp.2

10. *Women should have the right to more information about health*
11. *There should be more publicity about women's health facilities already available*
12. *There should be more ongoing research into diseases and conditions which are peculiar to women.*
13. *Handicapped (sic.) women should have access to all health facilities*⁷.

These aims and the Women's Charter remained the same over the period, although in 1987 a further statement was added to the Charter, stating that "*There should be increased effort to inform women about and protect them from hazards in the workplace.*"⁸ One interviewee commented on the Charter that,

I think many of us would think it was very inadequate now, but at the time it was quite progressive. (GGHB Interviewee 4)

The focus of the Clydeside Women's Health Campaign concerned medical and health care issues relating to the availability and accessibility of services and women's treatment by health care providers. The different needs of disabled and ethnic minority women were also highlighted. In addition, within a Newsletter discussing why women's health is an important issue it was reasoned that "*Women are different from men. They are built differently and have different emotions and needs*"⁹. Thus at this stage the focus for discussion on women's health was the inadequacy of health care provision, and on women's difference from men, physically and emotionally, rather than on gender inequalities. An interviewee commented

It wasn't consciously informed by a good appreciation of feminism. I think, paradoxically, although it was about women's issues and women's rights it was kind of more visceral, you know there weren't intellectual feminists in this, informing the debate. (GGHB Interviewee 9)

Several events were organised throughout the duration of the group, generally coinciding with International Women's Day¹⁰. As a campaigning group much of the activity centred on lobbying and information dissemination, through letters and newsletters. Issues

⁷ Women's Health Fair Working Group (1985) *Newsletter* (Glasgow : Women's Health Fair Working Group) pp.3

⁸ Clydeside Women's Health Campaign (1987) *Newsletter - February 1987* (Glasgow: Clydeside Women's Health Campaign)

⁹ Clydeside Women's Health Campaign (1986) *Newsletter - August 1986* (Glasgow: Clydeside Women's Health Campaign) p.1

¹⁰ Clydeside Women's Health Campaign (1986) *Minutes 11/03/86* (Glasgow: Clydeside Women's Health Campaign)

discussed included the planned closure of some maternity and family planning services¹¹; whilst newsletters contained articles on breast cancer and cervical screening; government cuts in maternity benefits and HIV/AIDS¹². The main issue concerning the Group however was the lobbying for the development of a Well Woman Centre. The idea for the establishment of a centre arose out of the Women's Health Fair and was seen as a means of demonstrating a model of good practice for women's health. A sub-group of the CWHC was formed to develop the campaign for a Centre, which became known as the Women's Health Action Group in 1989. This group later became the Women's Health Working Group. Campaigning for the development of the Centre was continued by the Women's Health Working Group, and became one of the 'Priorities for Action' included within the Women's Health Policy. Further discussion of the establishment of the Centre for Women's Health can be found later in this chapter as an 'Example of Action'.

Little information was identified regarding the outcomes of the other campaign issues identified by the Clydeside Women's Health Campaign. Although this Group continued to meet for a number of years following the development of the Healthy Cities Project Women's Health Working Group, its primary function can be seen as campaigning for the Centre for Women's Health and once these proposals had been accepted the group gradually came to an end. An interviewee commented

When the Centre was realised the Campaign did attempt to struggle on after that but it was very poorly attended by then... these women still felt that they had a role to play in making sure that this new service was delivered in a way that fulfilled the previous demands, and also to try to put pressure on organisations to make changes. But eventually it became too small to have any impact and dissolved itself by default. (GGHB Interviewee 9)

4.2.3 Women's Health Working Group and the Glasgow Healthy City Project

The establishment of the Glasgow Healthy City project represented a significant opportunity in formalising action on women's health in Glasgow. The principles associated with the WHO HCP have been reviewed within Chapter 2 as part of the

¹¹ Clydeside Women's Health Campaign (1986) *Minutes 15/01/86* (Glasgow: Clydeside Women's Health Campaign)

¹² Clydeside Women's Health Campaign (1987) *Newsletter - February 1987* (Glasgow: Clydeside Women's Health Campaign)

literature review. Of particular importance is the holistic model of health and the focus on the need for multi-agency working to improve health. In addition, it may be argued, Glasgow's membership of the Project opened up the opportunity for a broad model of health to be discussed as a legitimate concern within the organisations.

In 1988 Glasgow was invited by the WHO European HCP to participate in Phase 2 of the Healthy Cities Project, as

The WHO recognised the work that Glasgow had done on transforming many of the areas of decay and neglect and its status as a model for urban renewal. With the commitment to joint working and the involvement of the voluntary and community sectors in tackling the health problems of the city and its people, Glasgow fulfilled the criteria for membership of the Healthy Cities Project. (GHCP 1992:7)

The project was funded in equal parts by Greater Glasgow Health Board, Strathclyde Regional Council and Glasgow District Council. A Project Office was established, based within Glasgow District Council offices. Initially this Office was staffed by three full time officers, and later Urban Aid funding was obtained to finance a Community Health Support Unit which co-ordinated a number of community health projects within the City. Management of the Glasgow Healthy City Project was organised through a Steering Group and a Planning Group (GHCP 1992:11).

Women's health was one of five initiative areas identified by the Glasgow Healthy City Project Steering Group for 1990/91, and the Steering Group had requested that a meeting of the Women's Health Action Group be convened to provide 'input and impetus' to the Glasgow Healthy City Project¹³. Two members of the GGHB Health Promotion Department, who were also members of the Women's Health Action Group were asked to convene a meeting to prepare a list of practical initiatives that could be developed by the Glasgow Healthy City Project, investigate other ways by which the Centre for Women's Health proposal could be developed, and prepare a short report on how women's health could be included in other Healthy City programmes¹⁴. This meeting was held in April 1990, and attended by representatives from Strathclyde Regional Council, Greater Glasgow

¹³ Hanlon, P. (1990) *Letter to members of the Women's Health Action Group 21/03/90.*

Health Board, Glasgow Healthy City Project and the Clydeside Women's Health Campaign, and chaired by GDC Lord Provost, Susan Baird. This senior representation of the Lord Provost was seen by several interviewees as being of great significance, regarding it as an example that women's health was being 'taken seriously' as an issue.

A paper from the period, possibly drawn up for submission to the Steering Group, outlines the aims and objectives of the initiative as the following:

To draw up and co-ordinate a health plan for women in Glasgow by:

- *obtaining a Women's Health Strategy from each subscribing organisation*
- *ensuring the establishment and realisation of women's health strategies in local communities especially Health Cities pilot areas*
- *collating and integrating themes strategies into a health plan*
- *implementing the plan*
- *monitoring and evaluating the plan*

To facilitate the establishment of a Well Woman Centre in Glasgow by

- *obtaining suitable premises from Greater Glasgow Health Board*
- *devising an operational plan*

To develop a Women's Health Resource in conjunction with appropriate representatives from each subscribing organisation by

- *establishing and updating a database on women's health materials*
- *making these materials available.*¹⁵

Thus the idea for the development of a women's health policy can be traced back to the very beginning of the WHWG. The same paper also reveals that the Group sought to become a working group of the Glasgow Healthy City Project, recommending to the Steering Group that they invite the Women's Health Action Group to be reconvened as the Women's Health Working Group in order to progress the work¹⁶. Several interviewees involved at this time commented on the realisation of the benefits this could bring,

the Healthy City Project itself presented this new opportunity to get the statutory bodies more on board and kind of actually having a more strategic approach to it. So I think it was an opportunity that was seized quite rightly. (GDC Interviewee 12)

¹⁴ Hanlon, P. (1990) *Internal memorandum to Sue Laughlin and Margaret Robertson 13/03/90*

¹⁵ Women's Health Action Group (1990) *Healthy Cities Women's Health Initiative Paper* (Glasgow: Women's Health Action Group)

¹⁶ Women's Health Action Group (1990) *Healthy Cities Women's Health Initiative Paper* (Glasgow: Women's Health Action Group)

In this way, through the membership of the GHCP, action on women's health moved from a position of informal lobbying outside the organisations to become situated within the organisations themselves. As the GHCP opened up the opportunity for debates on a holistic model of health within the organisations, so it also enabled women's health to become part of those debates.

The WHWG continued to meet regularly, on the first Tuesday of every month throughout the period of research. The structure, membership, and role of this group will be discussed further later in this chapter.

4.3 Towards a women's health policy

Planning for the development of a Women's Health Policy began from the inception of the Women's Health Working Group in 1990. Despite the Group being part of the Healthy City Project, a '*recognised inter-agency initiative*', problems had been experienced by its members in persuading their employers of the value of the Group's work and the implications of their involvement as representatives. In addition the focus of the Group on women's issues and its challenge to the existing policies and practices of the organisations led to it being held 'at arms length' (Laughlin 1998:226). As such the development of a Policy was seen as a means of providing a '*lever for change*' within the organisations (Laughlin 1998:226).

The process began with the request for policy statements on women's health to be submitted by each of the participating organisations. In addition, the Australian 'Statement of the National Women's Health Policy' was circulated to the Group for consideration¹⁷. A Women's Health Working Group member became aware of the Australian policy through making a '*fortuitous contact*' at a conference in Amsterdam, and found that "*when I came back everyone else was thinking the same thing at the same time*" (GGHB Interviewee 4). In August 1990 a Policy Sub-group was convened to oversee the development of a draft policy¹⁸.

¹⁷ Women's Health Working Group (1990) *Minutes 06/06/90* (Glasgow: Women's Health Working Group)

¹⁸ Women's Health Working Group (1990) *Minutes 07/08/90* (Glasgow: Women's Health Working Group)

Discussions of the strategies needed to ensure the adoption and implementation of the Policy took place throughout the development process. The representatives had agreed that much of the work that had been conducted had depended on informal action by individuals and they were keen to secure action within the partner agencies. As a result, there was a recognised need to have the Policy ratified by organisations and their departments prior to its launch¹⁹. The Group planned to submit the draft Policy to the Healthy City Project Steering Group for consultation, and request that the senior personnel of the organisations appoint officers responsible for feeding back responses to the Women's Health Working Group²⁰.

The Draft document, "Women's Health Policy for Glasgow: a Framework for Discussion and Action", was launched for consultation on 17th May 1991. A copy of this draft document can be found in Appendix 3. The document highlights two main reasons for the need to consider women's health in particular: women's social role as carers and social status; and women's reproductive system and child-bearing. In addition to outlining the principles of health on which the Policy was based, five priority issues were identified: access to services; emotional and mental health; support for women as carers; reproductive health; and the reduction in the incidence of preventable disease ²¹.

A wide consultation of the draft policy took place, and many responses were received from statutory organisations, University of Glasgow, a range of voluntary organisations and individual women. Consultation meetings were held with community groups, and considered to be '*useful but poorly attended*'²². Inter-departmental briefing sessions were also held by GDC and SRC. During the consultation period the need to involve the Glasgow Healthy City Project and the partner agencies in the development of an action plan and 'pre-negotiate action' were again raised²³. The SRC Women's Unit and GDC

¹⁹ Women's Health Working Group (1990) *Minutes 06/06/90* (Glasgow: Women's Health Working Group)

²⁰ Women's Health Working Group (1991) *Minutes 24/04/91* (Glasgow: Women's Health Working Group)

²¹ Women's Health Working Group (1991) *Women's Health Policy for Glasgow: A Framework for Discussion and Action*. (Glasgow: Women's Health Working Group)

²² Women's Health Working Group (1991) *Minutes 03/09/91* (Glasgow: Women's Health Working Group)

²³ Women's Health Working Group (1991) *Minutes 01/10/91* (Glasgow: Women's Health Working Group); Women's Health Working Group Policy Subgroup (1991) *Minutes 20/11/91* (Glasgow: Women's Health Working Group)

Policy and Resources Committee were identified as possible avenues for implementation. No clear avenue was identified within GGHB however, but it was agreed that implementation should focus on both the purchasing and provider sides of the organisations²⁴.

At the end of the consultation period the responses to the draft were collated by the Policy Sub-group into four areas as follow:

Areas of agreement:

Focus; priority issues; Centre for Women's Health; need for participation, child-care, more information and health counselling.

Areas of disagreement:

Accusation of sexism; why women not people; assumption made of women's role as carer; not challenging carers role; language and style used in document; no research evidence to back up claims; confusion over meaning of 'access'.

Additional items of concern:

Violence against women; workplace health; ethnic health; environment; HIV & AIDS; school and education; poverty and food; alternative health; transport; gender and health; housing; attitude training for service providers; osteoporosis; agency women's forums.

Examples of good practice:

Gynaecological services, Stobhill; GDC looking at provision of shoppers crèche; pilot mental health clinic, East End; locally based services e.g. repair teams.²⁵

Thus, the consultation process highlighted several additional areas of concern, and also some level of anxiety on the focus of the policy. In particular both its emphasis on women, and the assumption of women's role as carers were emphasised.

In November 1991, the Policy sub-group agreed that the priority objectives, based on the responses received and the concerns of group members, should be: child-care; physical access and access to services; information and education; counselling, model services and professional and social attitudes²⁶. The group agreed that the Policy also needed to be more specific concerning the question of 'why women's health?' in particular, and that women's role as carers, whilst central to the Policy, should not remain unchallenged²⁷.

²⁴ Women's Health Working Group Policy Sub-group (1991) *Minutes 10/12/91* (Glasgow: Women's Health Working Group)

²⁵ Women's Health Working Group (1991) *Minutes 05/11/91* (Glasgow: Women's Health Working Group)

²⁶ Women's Health Working Group Policy Subgroup (1991) *Minutes 20/11/91* (Glasgow: Women's Health Working Group)

²⁷ Women's Health Working Group Policy Sub-group (1991) *Minutes 10/12/91* (Glasgow: Women's Health Working Group)

The Policy Sub-group began re-drafting the Policy in January 1992, a task which was described as 'difficult'²⁸. The aim of the Policy was revised to be "*To improve the health and well-being of women in Glasgow*". The Priority Issues remained largely the same as in the draft document, but with "access to services" being replaced by "health and safety at home and work". The section on women's health needs was however changed to read

- *mental health problems which relate to their role in society*
- *physical and mental health problems which relate to their biological function*
- *physical and mental health problems that are not always sympathetically dealt with*
- *a risk of domestic and sexual violence*²⁹

A set of four new objectives were included in the Policy:

1. *To raise awareness about women's health needs and an understanding of a women's health perspective*
2. *To introduce this awareness into policy and planning processes of statutory and voluntary agencies*
3. *To ensure women's health needs and a women's health perspective are incorporated into the delivery of all services*
4. *To ensure the provision of services and support specifically for women.*³⁰

A total of 34 recommendations were attached to these objectives, and four 'Priorities for Action leading to Good Practice' were identified. Each of the partner organisations were asked to

1. *Identify a committee or forum to ensure the implementation of the Healthy Cities Women's Health Policy*
2. *Introduce awareness training for decision-makers*
3. *Make available in Glasgow a Centre for Women's Health which is adequately funded and resourced*
4. *Improve inter-agency co-operation by ensuring representation on the Women's Health Working Group.*³¹

A copy of the Women's Health Policy can be found in Appendix 1.

²⁸ Women's Health Working Group (1992) *Minutes 07/01/92* (Glasgow: Women's Health Working Group)

²⁹ Women's Health Working Group (1992) *Women's Health Policy for Glasgow* (Glasgow: Women's Health Working Group) p.3

³⁰ Women's Health Working Group (1992) *Women's Health Policy for Glasgow* (Glasgow: Women's Health Working Group) p.4

³¹ Women's Health Working Group (1992) *Women's Health Policy for Glasgow* (Glasgow: Women's Health Working Group) p.9

The representation of 'women' in the final policy document is as a homogenous group. It was decided that the policy should highlight the needs of all women and rather than highlight the specific needs on the basis of class, disability, race or sexuality. In addition, 'women's difference' to men as particular health needs are seen as resulting from both women's 'social role' and their 'biological function'. Indeed, as will be discussed later, representation of women's 'social role' is closely linked with their 'biological function'.

In exploring the objectives and recommendations of the Policy, the problem represented centres on women's insufficient and inappropriate access to: knowledge, information, services, resources and choice. Beyond this the problem representation as detailed in the Policy objectives concern both cultural and structural organisational barriers to women's health. Emphasis is placed on the need to raise awareness of women's health needs and a women's health perspective in all organisations and at all levels, but particularly at senior management and decision-making levels. Hence the problem is represented to be a lack of understanding and awareness, and a barrier to that understanding being included in policy and planning existing at the level of senior managers and decision-makers. Additional emphasis is placed on the need for work on women's health to be seen as a priority in all areas and all organisations, for women to be represented in decision-making and women's groups consulted with. Thus the problem is represented to be a lack of priority attached to women's health, exacerbated by the lack of inclusion of women in decision-making. A related concern can be seen in the recommendation and priority for action that women's health forums and committees be formed to 'ensure implementation'. As such the problem is represented to be the lack of structural channels for communication and decision-making on women's issues and the lack of inclusion within the mainstream structures within the organisation.

The Women's Health Policy document was finalised in March 1992, and launched on 18th June 1992, when the partner agencies publicly adopted the document. The launch was reported to have been a success and the Policy was circulated to groups and organisations in Glasgow and across Scotland. A separate community launch of the Policy took place in March 1993 that was attended by representatives from approximately 70 groups.

In summary, the development of the Glasgow Women's Health Policy can be seen as organic and evolving, the result of a series of events in which women in the city of Glasgow sought to improve the health of women. The focus for action has reflected the motivations behind the British women's health movement highlighted by Doyal (1983). That is: women's reproductive health needs; women's health care needs; defending the NHS; and the development of a Well Woman Centre. However the case in Glasgow contains a number of innovations. The action can be seen as a combination of opportunistic and strategic approaches, responding to chance events whilst simultaneously looking for avenues to increase its success. One clear example is the opportunity provided by the development of the Glasgow Healthy City Project for campaigning on women's health to move from outside organisations, to being part of the overall structure of the project. In addition, a multi-agency approach to health can be traced back to the organisation of the Glasgow Women's Health Fair.

4.4 Organisational structures and processes

So far this chapter has focused on reviewing the processes associated with the development of action on women's health and the Women's Health Policy. Here, the emphasis changes to exploring the implementation of the Policy. One of the 'Priorities for Action' within the Women's Health Policy was the identification of a forum within the partner organisations to oversee the implementation of the Policy within that agency. Such fora were identified or established, and these structures provided the primary means through which the analysis of the implementation of the Women's Health Policy has been conducted. Beginning with the Women's Health Working Group, each forum will be discussed in terms of: structure, representation, the role of the Group, and the priorities for action established.

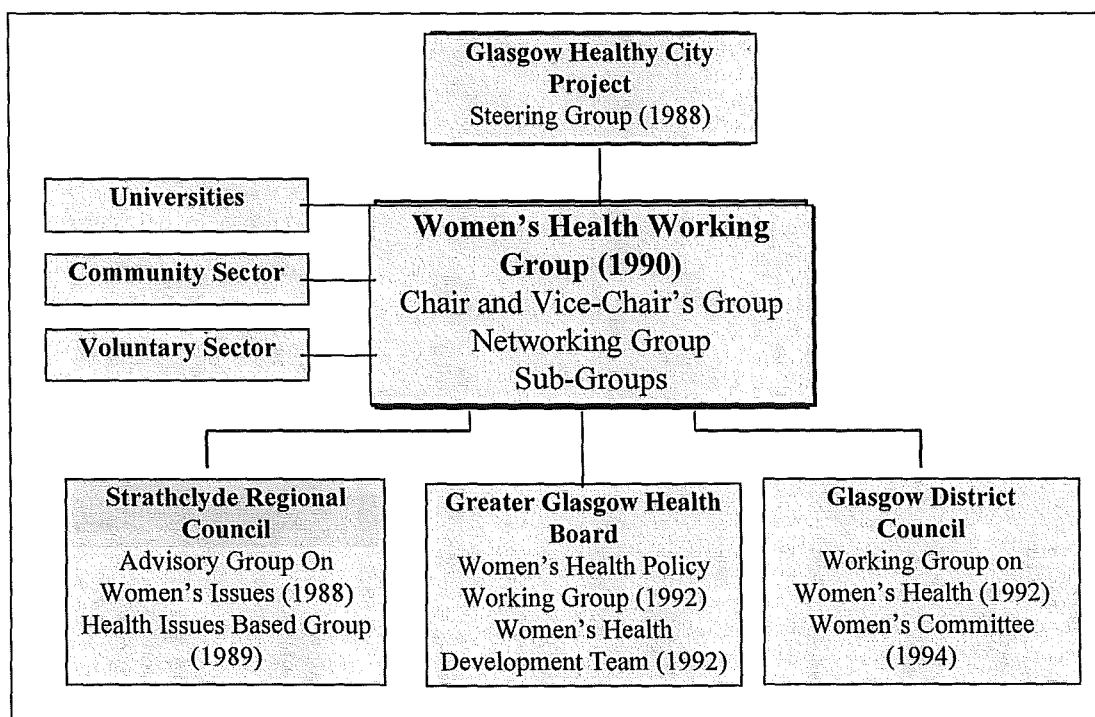
4.4.1 Women's Health Working Group

4.4.1.1 Structure

The structure and multi-agency representation on the Women's Health Working Group continued unchanged after the launch and adoption of the Policy by the partner agencies. However, the external linkages of the WHWG changed as structures were established or

identified within the statutory partner agencies. These were intended to act as a formal route of communication and oversee the implementation of the Policy within these organisations. Figure 4.2 depicts the relationship of the Women's Health Working Group with the partner agencies and the Glasgow Healthy City Project.

Figure 4.2: Women's Health Policy - multi-agency structures



Note: Dates in brackets denote year forum established.

The Women's Health Working Group was an open and participatory forum, with approximately 80 organisations and groups on the mailing list, and between 10 and 20 members attending the monthly meeting. The work was co-ordinated by the Chair of the Group, assisted, after 1995, by a number of vice-chairs.

Subgroups were established by the Women's Health Working Group as a means of progressing particular pieces of work in more detail. In the main these took two forms: issue based groups such as on disabled or black and ethnic minority women's health and continued to meet for long periods; and task based groups which were established to perform a particular piece of work and were frequently time limited. Table 4.1 provides

details of the subgroups established in each year, with the issue based sub-groups in bold type.

Table 4.1: Women's Health Working Group Sub-groups 1991-1996

1991	1992	1993	1994	1995	1996
Women's Health Policy; Event/Launch	Women's Health Needs Assessment; Information	Black and Ethnic Minority; Disabled; Partners; Complementary Therapy; Mini-mag; Forward Plan	Equal Opportunities; MCAP June Event; Planning Day; Mental Health;	Lesbian Health; Action Pack; Poverty	Policy Review; WHWG Restructuring; Vice-Chairs; Policy launch; Network Meetings

4.4.1.2 Representation and attendance

The representation of the WHWG was seen by several interviewees as evolving. Due to the nature of its development out of one group and transformation into another, its membership was not planned at the outset. As one interviewee noted

it has always been a kind of mixture of interested individuals with efforts to get proper representation from the partner organisations on it and I don't think we have ever got that right... but in some ways that's a strength, that women do feel that they can just join and find out what's going on, and some stay and some don't stay. (GGHB Interviewee 9)

The statutory sector members of the Women's Health Working Group who were interviewed as part of this research became involved with the Working Group for one of three reasons. Firstly four GGHB interviewees and one SRC interviewee began their involvement with the Clydeside Women's Health Campaign. Secondly, the majority of interviewees from each of the partner agencies related their involvement to their position within their organisation, including those who had been involved in the Clydeside Women's Health Campaign. In the main this referred to their strategic position in terms of having a women's issues remit or involvement with the Glasgow Healthy City Project. Finally a small number of GDC and SRC interviewees said that their involvement had been requested by the Women's Health Working Group, either because of their political position or to represent specific groups such as disabled and black and ethnic minority women.

A number of these women highlighted their representation on the Women's Health Working Group as being 'official', in terms of representing their organisation, department

or interest group. Others who became involved at a later stage highlighted their involvement as being due to interest and their ability to become involved due to their job remit. What is interesting to note is that all the Women's Health Working Group interviewees commented that they had a long-standing interest in women's issues, and that those whose attendance had been requested were approached by the Women's Health Working Group rather than being nominated by their department or organisation. As such they were willing participants in the Group, in contrast to some of the organisational women's fora representatives who had been delegated the task of attending the fora, and were less positive about their involvement, as will be discussed later.

Whilst membership of the WHWG was open to all, debates within the Group frequently turned to the question of the representation of different organisations and sectors within the Group. These discussions invariably involved the need to increase senior representation on the group, and expand the range of organisations represented. Susan Baird, the Lord Provost and Chair of the Group, left towards the end of 1990 and several attempts were made to broaden the representation on the Group. Representation was sought from elected members within GDC and SRC in particular, in order to secure access to the decision-making structures and 'political clout'. In addition, a primary care nurse, a University representative and further members from the voluntary sector, including AIDS, homelessness, elderly and ethnic minority representatives were also sought ³².

The lack of community representation was repeatedly highlighted at group meetings³³. Although it was felt that the Women's Health Working Group was in danger of becoming an exclusively workers group, by the end of 1991 this concern changed to a feeling that local women's inclusion may "*change the focus of the group*". That is, by being more inclusive, there was a risk that the strategic focus of the group would be diluted. It was resolved that if issues emerged of particular interest to local areas groups would be contacted at that point³⁴. The lack of community involvement continued to be a concern to members of the Women's Health Working Group. In early 1995 one of the vice-chairs was

³² Women's Health Working Group (1991) *Minutes 03/09/91* (Glasgow: Women's Health Working Group)

³³ Women's Health Working Group (1991) *Minutes 05/11/91* (Glasgow: Women's Health Working Group)

³⁴ Women's Health Working Group (1991) *Minutes 03/12/91* (Glasgow: Women's Health Working Group)

given the responsibility to work on developing links that already existed with women in the community³⁵, and in 1996 a series of Network Meetings was launched in the hope of consulting with women in local communities about their health needs.

Concern about the under-representation of ethnic minority people on the group led to a 'one-off' meeting for ethnic minority organisations being arranged to discuss the issue³⁶. No new organisations were represented at this meeting.³⁷ These debates continued after the launch of the Policy, prompted by correspondence from groups who were concerned that the needs of ethnic minority and disabled women were not expressed in the Policy³⁸, and the lack of involvement of ethnic minority women in the Women's Health Working Group³⁹. Disabled women's and black and ethnic minority women's health sub-groups were later established by the Women's Health Working Group to develop work in these areas.

The Women's Health Working Group also tried to extend its range of departmental representation from the partner agencies⁴⁰. The issue of representation arose again following the Planning Day in 1994, at which identified gaps included representation of: carers; the elderly; youth; unemployment; learning disabilities; and mental health⁴¹. Some additional members were secured from voluntary organisations, but the Women's Health Working Group experienced difficulty in maintaining representation from voluntary organisations. Often a representative would attend for one or two meetings and then not return.

Analysis of the attendance of Women's Health Working Group meetings has been conducted using Working Group Minutes for the years 1990-1996. The intention of this analysis is to highlight the composition of the various sectors attending Women's Health

³⁵ Women's Health Working Group (1995) *Minutes 10/01/95* (Glasgow: Women's Health Working Group)

³⁶ Women's Health Working Group (1991) *Minutes 05/11/91* (Glasgow: Women's Health Working Group)

³⁷ Women's Health Working Group (1992) *Minutes 07/01/92* (Glasgow: Women's Health Working Group)

³⁸ Women's Health Working Group (1992) *Minutes 03/11/92* (Glasgow: Women's Health Working Group)

³⁹ Women's Health Working Group (1992) *Minutes 01/12/92* (Glasgow: Women's Health Working Group)

⁴⁰ Women's Health Working Group (1992) *Minutes 01/12/92* (Glasgow: Women's Health Working Group)

⁴¹ Women's Health Working Group (1995) *Minutes 10/01/95* (Glasgow: Women's Health Working Group)

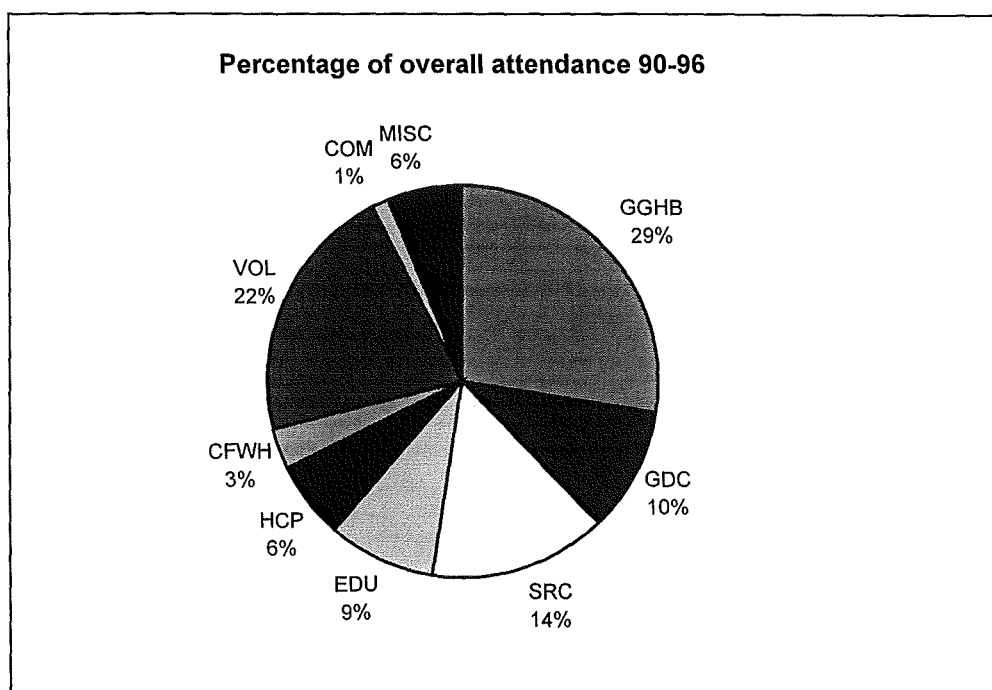
Working Group meetings. This is of interest due to the multi-agency nature of the forum. Table 4.2 details the average attendance at meetings by year and group.

Table 4.2: Average attendance at WHWG meetings by year and group.

GROUP	YEAR							
	1990	1991	1992	1993	1994	1995	1996	Overall
GGHB	2.2	2.3	4.3	6.8	5.0	4.2	4.4	4.2
GDC	0.2	1.8	1.7	1.7	2.1	1.6	1.5	1.5
SRC	2	1.8	1.4	2.8	1.9	3.0	1.7	2.1
EDU	0.0	1.0	1.8	1.6	1.6	1.3	1.9	1.3
GHCP	0.2	0.8	0.7	1.3	1.2	1.5	1.0	1.0
CFWH	0.0	0.0	0.0	0.4	1.0	1.3	0.9	0.5
VOL	1.6	3.5	4.1	3.7	4.7	2.9	2.0	3.2
COM	1.0	0.0	0.0	0.0	0.1	0.1	0.4	0.2
MISC	2.4	0.3	0.6	0.6	0.8	0.2	1.6	0.9
TOTAL	9.8	11.7	14.4	18.8	18.3	15.9	15.4	14.9

As can be seen, in terms of overall attendance 1990-1996, GGHB recorded the highest number of attendees per meeting in each year, followed by the voluntary sector. However the voluntary sector figure represents the attendance of a changing range of organisations. In contrast, the community sector despite being initially represented in 1990, was not represented at Women's Health Working Group meetings again until 1994, and then extremely infrequently. Figure 4.3 graphically demonstrates the proportion of attendance of the sectors 1990-1996.

Figure 4.3: WHWG - Percentage of overall attendance by group 1990-1996



In addition to the changing representation, the level of involvement or commitment of individual members in the Group was also a concern. In early of 1991 a letter was sent to the members of the WHWG requesting their increased support and involvement in the planned activities of the group which were being left to a small number of women to organise⁴².

4.4.1.3 Role of the Group

There was a degree of consensus between the Women's Health Working Group interviewees as to how they perceived the role of the Group. Firstly GDC and SRC representatives in particular highlighted its role as a network. Several interviewees commented on the benefits they had gained through membership of the group in terms of support from women working on similar or related issues and the Group's function as a means of exchanging information.

I think it very importantly provides support for a number of us who have been very isolated for a long time within organisations who don't necessarily see our priorities as their priorities and don't necessarily see that a response is required from them (SRC Interviewee 17)

⁴² Laughlin, S. (1991) Letter to members of Women's Health Working Group 16/01/91

In addition to being an information exchange for Group members, some interviewees highlighted the role of the Group as acting as a two-way conduit, bringing information into the Group, but also taking information back out to the organisations. As one interviewee noted,

those of us who were members would take the issues that were raised back to their organisations, (a) from the point of view of information, so that we would be informing our own organisation of what was happening, but (b) to make sure that the organisations were having some kind of input into the work of the Women's Health Working Group (SRC Interviewee 20)

This links into the second perceived role of the Women's Health Working Group, that of awareness raising outside of the group itself. Interviewees commented both on the role of the group in developing a broader understanding of what health is, and in raising the profile of women's health.

Well I think it has always been its role to keep the banner flying if you like, for what women's health is and what you need to do to improve women's health, and to provide an analysis of why women's health is important. (GGHB Interviewee 4)

Finally a third role of the Women's Health Working Group as perceived by statutory sector members was to seek to implement the Women's Health Policy. For some this implementation role was characterised as indirect, in trying to encourage the organisations to implement the Policy; seeking to inform other organisational policies through responding to consultation documents; or requesting representation on other groups or committees. Others saw a more direct role in seeking to implement the Policy through developing ideas and models of good practice. A small number of interviewees identified their own role as members of the Women's Health Working Group as being to integrate the work of the Working Group and the Women's Health Policy into mainstream policies and services within their organisations. However others felt that it was not the role of the Women's Health Working Group itself, as one interviewee noted,

I don't think it should have a role in implementing it. I think it should be encouraging and facilitating its implementation. I mean it's not responsible for service delivery, it's not responsible for policy decisions. The organisations that are partners of Healthy Cities are responsible for all those and they need to take the responsibility for implementing it. But it's not going to happen unless pressure

is put on them to do that, and I think that is where the role of the Women's Health Working Group lies. (GGHB Interviewee 9)

4.4.1.4 Priorities for action

The priorities for action identified by the Women's Health Working Group demonstrate its multi-faceted role, and include awareness raising, developmental work and strategic planning.

In the initial period following the launch of the Policy the Women's Health Working Group focused on trying to ensure the adoption and implementation of the Women's Health Policy by the partner organisations and the 'Priorities for Action' as contained within the Policy. In August 1993, a forward plan was produced⁴³, which alongside the monitoring of the implementation of the Women's Health Policy within the partner agencies, highlighted the following issues for development: the health of ethnic women; health of disabled women; alternative therapies; and mental health. Additional priorities included: raising awareness of women's health and the Women's Health Policy; support for women's health groups; and needs assessment. From November 1993, a series of annual Planning Days were organised, which were used to review the work of the Working Group, strategies for implementation and establish future priorities.

Aside from discussing thematic issues, Planning Days commonly featured debates concerning the role and remit of the Women's Health Working Group and its sub-groups. Additional thematic concerns developed over the years include: community care; poverty and inequality; violence; sexual health and sexuality; age; and sustainability. Work relating to the priority issues was largely pursued through the establishment of sub-groups.

4.4.2 Greater Glasgow Health Board: Women's Health Policy Working Group

4.4.2.1 GGHB Organisational Structure

Greater Glasgow is one of the fifteen Health Boards in Scotland which oversee the provision of health care services. Greater Glasgow Health Board was restructured during

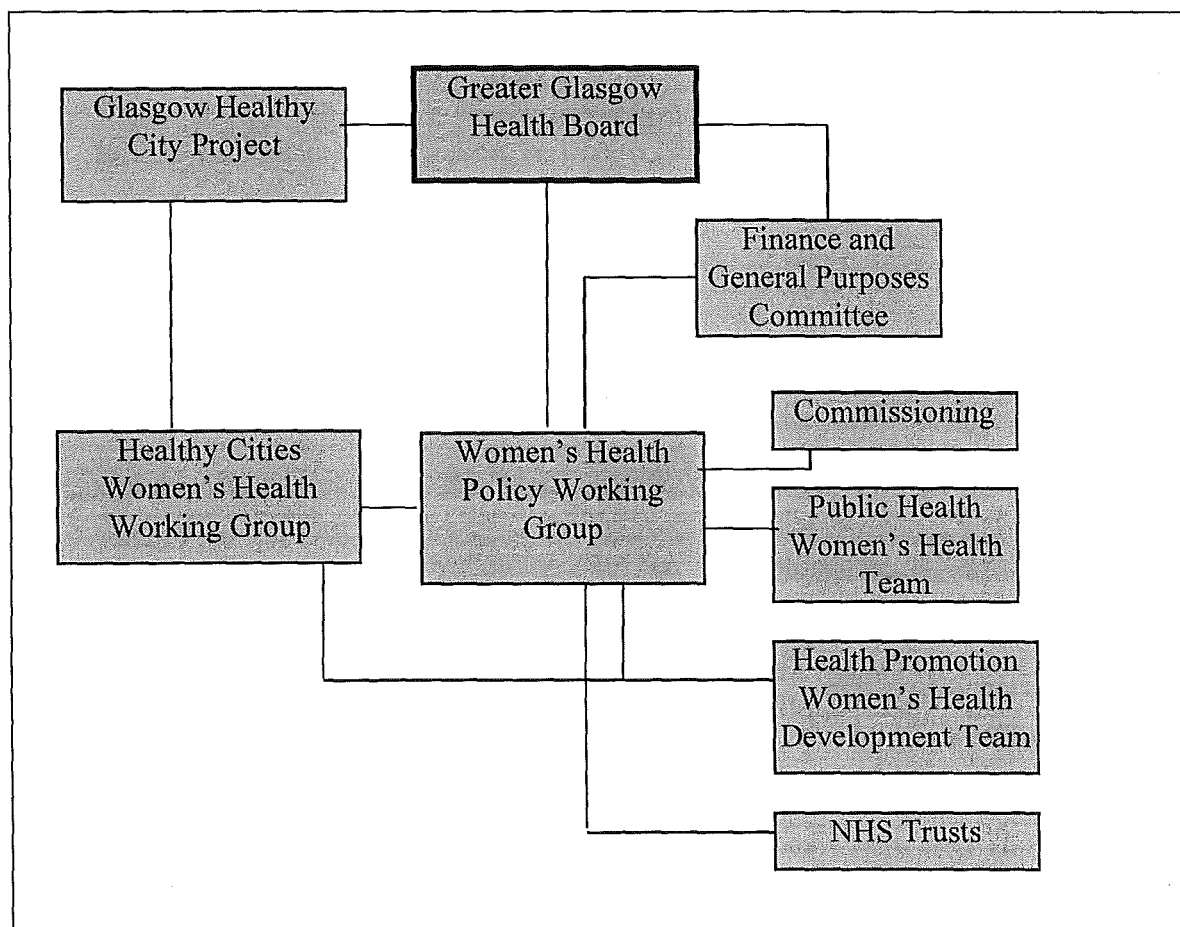
⁴³ Women's Health Working Group (1993) *Women's Health Working Group Forward Plan from August 1993*.

the period of analysis due to the fundamental reforms taking place within the NHS. This involved the transformation of the GGHB from a providing to a commissioning organisation, purchasing services from the newly established NHS Trusts. The Women's Health Policy was adopted by the Health Board during this period of change, and as such the organisational structure of the Greater Glasgow Health Board will be discussed within this context.

Greater Glasgow Health Board consists of a number of executive and non-executive members who ratify the decisions of the organisation. The main decision-making body within the organisation is the Finance and General Purposes Committee, through which all proposals with resource implications must be passed before going to the Board for approval. Following the purchaser/provider split within the organisation, two service departments or directorates remained: Health Promotion and Public Health. The other key directorate is planning and contracts/commissioning, which draws up the contracts or service agreements with the NHS Trusts. GGHB also comprises a number of other sections such as administration, finance, and property. Nine NHS Trusts were established of differing size and with different remits or areas of specialism, such as the Dental Hospital, Community and Mental Health Services, and acute services. [The NHS Trusts in Glasgow have been further restructured in the period subsequent to the analysis in this thesis.]

The organisational structure through which the Women's Health Policy was intended to be implemented, the Women's Health Policy Working Group, was established after the formal adoption of the Policy by Greater Glasgow Health Board in 1992. Figure 4.4 demonstrates this GGHB organisational structures:

Figure 4.4: GGHB Decision-making Structure



4.4.2.2 Structures

Women's Health Policy Working Group

Following the adoption of the Women's Health Policy the Greater Glasgow Health Board agreed that a short-life working group should be set up to review the Policy and make recommendations about which elements should be taken forward ⁴⁴. The Women's Health Policy Working Group (WHPWG) first met in August 1992 ⁴⁵ and, following the review of the Policy, recommended the appointment of a Women's Health Policy Co-ordinator to oversee the implementation of the Policy ⁴⁶. It was also recommended that the Working Group should continue to meet, as whilst the Policy "*should be implemented through the normal management structures of the Board, other issues... will have to be considered and*

⁴⁴GGHB (1992) *Minutes of the Meeting of the Finance and General Purposes Committee (16/06/92)*

⁴⁵Greater Glasgow Health Board (1992) *Women's Health Policy Working Group Minutes (05/08/92)*

⁴⁶GGHB (1992) *Minutes of the Meeting of the Greater Glasgow Health Board (20/10/92) Board Paper 92/38*

developed into more detailed plans"⁴⁷. These recommendations were approved by the Board, and Finance and General Purposes Committee in November 1992⁴⁸. The remit of the Group was proposed as follows:

1. *Oversee the implementation of the recommendations of the Women's Health Policy outlined in the Board paper of October 1992*
2. *Develop and implement the medium and long-term recommendations of the Women's Health Policy*
3. *Oversee the work of the Women's Health Co-ordinator*
4. *Liaise with the Healthy Cities Women's Health Group*
5. *Liaise with staff designated by the Healthy Cities partner agencies to implement the Women's Health Policy in these agencies*
6. *Identify new issues and initiatives in Women's Health as they arise and assess their relevance to GGHB.*⁴⁹

A non-executive Director of the Board was selected to Chair this which enabled the group to feed into the management structure of the Board through the presentation of papers and an annual report.

Key departments/individuals

In the 1980s, the Public Health Department had appointed a Consultant in Public Health with the remit of women's health. This Consultant had established a team of staff on "soft monies", conducting research on women's health to inform Board policies and strategies, which latterly became more formalised as the Women's Health Team. Following the launch of the WHP, and on the recommendation of the Women's Health Policy Working Group, the Finance and General Purposes Committee agreed to the funding of a Women's Health Policy Co-ordinator in November 1992. The Co-ordinator was to be assisted by the Consultant in Public Health Medicine for Women's Health, and the Senior Health Promotion Officer for Women's Health, who had "*agreed strict lines of co-operation and demarcation*"⁵⁰. The Women's Health Policy Co-ordinator is based within the Public Health Department of the Board and works with the Women's Health Team within the Department. As such, the GGHB has a key officer with responsibility for overseeing the implementation within the organisation, and liaising with the other GHCP partner agencies.

⁴⁷ GGHB Women's Health Policy Working Group (1992) *Healthy Cities Women's Health Policy: A Report by the GGHB Women's Health Group* (06/10/92)

⁴⁸ GGHB (1992) *Women's Health Policy Working Group Minutes* (09/11/92)

⁴⁹ GGHB (1992)

⁵⁰ GGHB (1993) Internal Memorandum - Dr P Hanlon to Dr G D Forwell and Mr T A Divers (23/04/93)

In addition the Health Promotion Department had a Senior Health Promotion Officer for Women's Health, and a Women's Health Development Team was established within that department in 1992 to oversee the progression of women's health work within the department. The Chair of this group was a representative on both the GGHB Women's Health Policy Working Group and the GHCP Women's Health Working Group.

4.4.2.3 Representation

Initially the Women's Health Policy Working Group comprised primarily of Board-based personnel, with representation from a number of key service areas such as Family Planning and the Community and Mental Health Services Unit. Following the NHS restructuring in 1993 it was noted that there were no NHS Trust representatives on the Working Group, and in late 1994 it was recommended that membership be increased to include a representative from each of the NHS Trusts ⁵¹. Representatives were secured for the majority of Trusts, and were intended to be a means of facilitating the implementation of the Women's Health Policy within these organisations.

In relation to the representatives interviewed, a number of, mainly Health Board-based, employees, had a long involvement with women's health, having also been involved in the Clydeside Women's Health Campaign and the GHCP Women's Health Working Group. Five interviewees had become involved in the Group following requests for them to join, largely because of the position they held within their organisation or their specialism. Those requested to join by the Group came from both the Health Board and the Trusts and were largely also long-standing members. Four interviewees said that they had become members of the Group as a result of being delegated by their organisations, replacing other, more senior, representatives who did not have time to attend the meetings, or being delegated the task because of their sex. Some delegated members commented negatively about their involvement.

We were asked for a nursing representative, and I think that's why I went, kind of half-heartedly I would have to tell you. I actually quite enjoyed the meetings but I

⁵¹ GGHB (1994) *Women's Health Policy Working Group Minutes (08/12/94)*

was kind of volunteered rather than volunteering to go. (GGHB Trust Interviewee 3)

Members of the Women's Health Policy Working Group who had been delegated to attend had been involved for a shorter period of time, generally joining during 1995. Therefore, in contrast to the WHWG, it can be seen that some representatives were not entirely willing participants.

4.4.2.4 Role of the Group

The majority of WHPWG interviewees perceived the role of the Group to be primarily a network and a means for exchanging information. A number of interviewees felt that it was a forum for developing ideas, whilst others saw the Group as having an implementation role, in terms of raising awareness of the Policy and raising the profile of women's health:

The role of the group is I think to try and have women's health at the forefront of all agencies and all health specialities, so that they're aware of the need for it and the problems of women in particular. (GGHB Trust Interviewee 1)

Some Trust employees emphasised that the group had an advisory rather than an implementation role, although recognising their responsibility as members to facilitate the implementation within their organisations.

I think at the end of the day we can only really comment on things and can't really action anything as a group. It's up to us as individuals in our own areas to push things through. (GGHB Trust Interviewee 8)

Some Board-based members saw the role of the Group as developing an 'interface' between the Health Board and the Trusts. A few interviewees commented on the intended active role that they felt the group should have had. One interviewee presented a different role of the Group, as an important symbol of the formal commitment of the organisation to the progression of women's health issues.

Having it does imply at least some recognition by the Board and by the Trusts that they are committed to it... I think it's very important to get things legitimised by having some formal structures. I don't think it necessarily makes them work but I think it's very important to have them there. (GGHB Interviewee 9)

4.4.2.5 Priorities for Action

Priorities for action within GGHB were developed through the establishment of a sub-group of the WHPWG, to review the current activity within the Board, the relevance of the Policy recommendations and produce a timetable for action ⁵². This group concluded that all 34 recommendations contained within the Policy were relevant to some degree, and in October 1992 asked the Board to agree that the recommendations should be adopted in a phased programme, including the following six for immediate implementation:

- a) provision of improved information about women's health and existing health services*
- b) extension of the "Ballantay model" of well woman's services*
- c) incorporating women's mental health issues into mental health planning*
- d) raising awareness about the Women's Health Policy with Health Board staff*
- e) integration the above activities with the proposed Centre for Women's Health at the Eye Infirmary*
- f) incorporation of a women's health perspective into the Boards purchasing activities.*⁵³

Over time other priorities emerged, including black and ethnic minority women's health needs, women and heart disease, domestic violence, and the health of female staff.

As with the GHCP Women's Health Working Group, sub-groups were commonly established by the Women's Health Policy Working Group as a means of carrying forward work on particular issues. In August 1994 four sub-groups were established: heart disease; abused women (later called domestic violence); health of female staff; and mental health⁵⁴. These groups continued to meet for the remainder of the period of analysis, with the exception of the heart disease group which appears to have been subsumed into the activities of the Heart Health Gain Commissioning Team through adding a gender perspective to their study of the incidence of heart disease⁵⁵.

⁵²GGHB (1992) *Women's Health Policy Working Group Minutes (05/08/92)*

⁵³GGHB (1992) *Minutes of the Meeting of the Greater Glasgow Health Board (20/10/92)* Board Paper 92/38

⁵⁴GGHB (1994) *Women's Health Policy Working Group Minutes (18/08/94)*

⁵⁵GGHB (1995) *Women's Health Policy Working Group Minutes (23/01/95)*

4.4.3. Glasgow District Council Working Group on Women's Health/ Women's Committee

4.4.3.1 GDC Organisational Structure

Glasgow District Council was the largest district authority in Scotland, formed in 1974 after local government reorganisation created a two tier system of local government and operated until the subsequent reorganisation in 1996. The Council was traditionally a Labour-controlled authority with, in 1991, 59 of the 66 members forming the Labour administration. The Council had 17 main departments, plus a myriad of other units and responsibilities. As an elected body, the decision-making of the Council takes the form of a committee structure. The Council in 1995 had 15 full committees, with a total of 47 sub-committees and working groups, and 10 area management committees. Membership of these committees is restricted to elected members of the Council, with departmental officers attending.

The organisational structure through which the Women's Health Policy was implemented was established after the formal adoption of the Policy by Glasgow District Council in 1992. Initially this structure comprised of the Working Group on Women's Health Policy, a working group of a Policy and Resources sub-committee. Later, in 1994 the responsibility was transferred to the newly established Women's Committee.

4.4.3.2 Structures

Working Group on Women's Health Policy

A Working Group on Women's Health Policy was established in September 1992 as a working group of the City, Environment and Health Sub-Committee of the Policy and Resources Committee ⁵⁶. This Sub-committee, through its Convener, linked into the Glasgow Healthy City Project Steering Group. It was agreed that it would be a member/officer group, chaired by a councillor. Initially membership was to include three councillors and representatives from the following departments: Libraries, Environmental Health; Personnel; and Town Clerk's⁵⁷. In subsequent months two further councillors were

⁵⁶ GDC Policy and Resources Committee (1992) *City Environment and Health Sub-Committee Minutes (16/09/92)*

⁵⁷ GDC Policy and Resources Committee (1992) *City Environment and Health Sub-Committee Minutes (16/09/92)*

appointed and the Directors of Housing, Parks and Recreation, Planning, and Building Control were asked to nominate representatives ⁵⁸.

In relation to the development of the Working Group on Women's Health Policy, a small number of GDC interviewees spoke of the establishment of the group being 'sensitive'. The establishment of the Group was seen by many as being a precursor for a Women's Committee, a development which was not widely supported. Indeed one interviewee commented that the establishment of a women's health group was seen as being politically less sensitive than seeking a full women's committee.

We set up a Working Group on Women's Health Policy which was easier to accept politically than a women's committee, and because it was so successful and its remit become so huge that we argued that we needed a full Women's Committee with a budget and a Women's Unit. I think that's a major success and I'm convinced that wouldn't have happened without the Women's Health Policy. (GDC Interviewee 13)

A further issue concerned the remit of the Group which was seen to be operating in a new area for the council, with the perception that it may be acting on issues outwith the responsibility of the Council. As one interviewee noted,

it was dealing with an area of policy which was not strictly the Council's responsibility and local authorities have got to be careful about the certain restrictions of what we can and can't do. It's straying into an area which is the responsibility of the local Health Board which is one area we couldn't become involved in. (GDC Interviewee 1)

With the establishment of the Women's Committee in late 1993 responsibility for the GWHP was transferred to that Committee. However, concerns about the overlapping remits of these structures, led to the GWHP being restructured to become

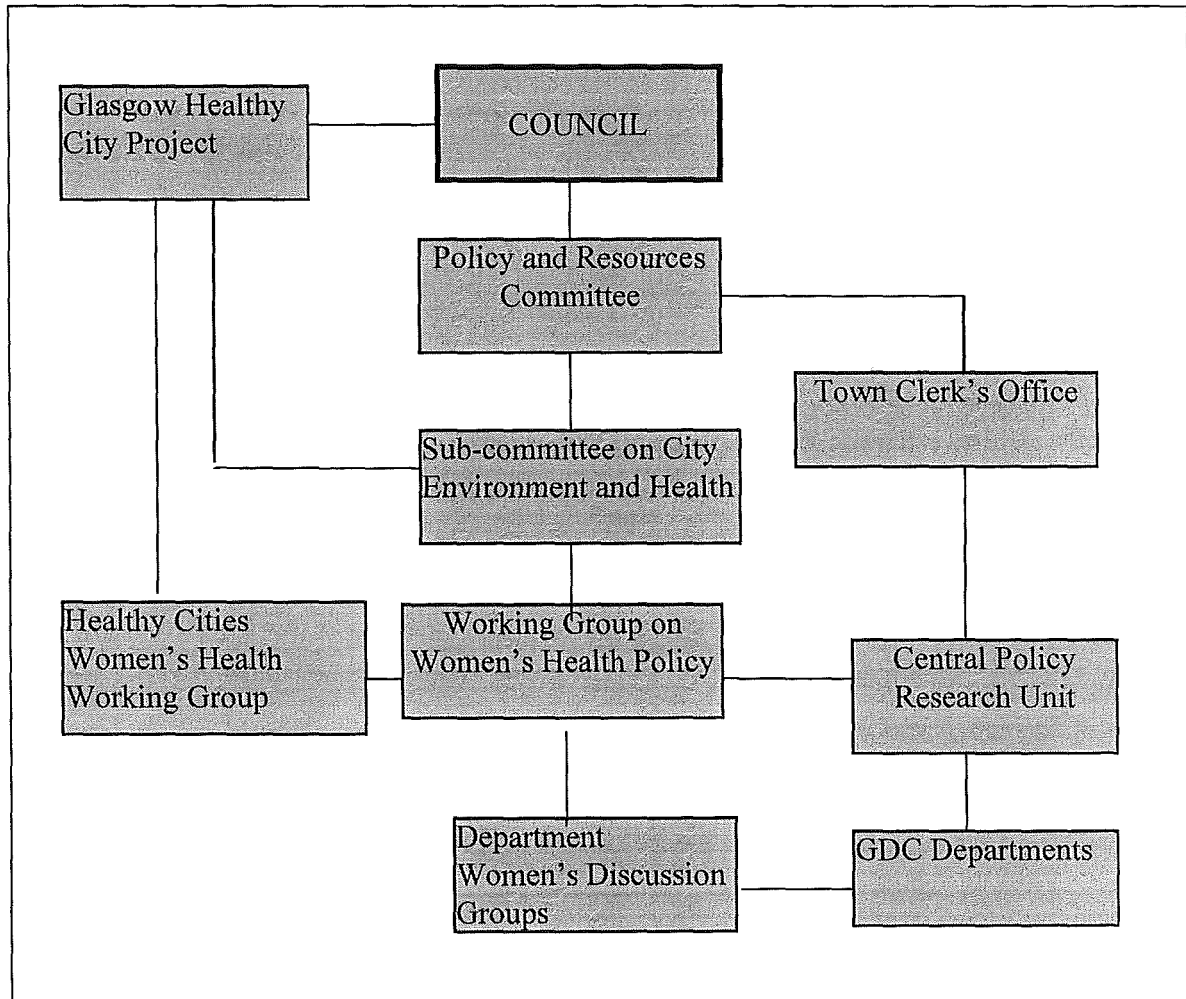
a project-based group, perhaps operating on an ad hoc basis, dealing with particular topics or issues either as directed by the Women's Committee or generated by the group itself. ⁵⁹

⁵⁸ GDC Policy and Resources Committee (1992) *Working Group on Women's Health Policy Minutes* (26/10/92)

⁵⁹ GDC Women's Committee (1995) *Working Group on Women's Health Policy Minutes* (18/09/95)

Figure 4.5 demonstrates the GDC decision-making structure relating to the Women's Health Policy prior to the establishment of the Women's Committee.

Figure 4.5: GDC Decision-making Structure 1992-1994



Women's Committee

The establishment of a women's committee was a manifesto pledge made by the Glasgow Labour Party at the local government elections in May 1992. The appointment of a Women's Committee was approved at a meeting of the Council in October 1993⁶⁰, with the following remit:

- i) formulating policies to promote the welfare and interest of women and make recommendations to the service delivery committees,*
- ii) liaising with and giving financial assistance to women's groups and organisations, and*

⁶⁰Glasgow District Council (1993) *Council Meeting Minutes (28/10/93)*

*iii) undertaking specific initiatives on issues affecting women.*⁶¹

The committee was allocated a budget, and it was also agreed to establish a Women's Unit to be based within the Town Clerk's Office, comprising of a Head of Women's Unit and a researcher. Membership of the Committee included four Bailies, seventeen councillors, plus the Convener and two sub-conveners. In addition two trade union co-optees were appointed.

Several GDC interviewees spoke of positive impact of the establishment of the Women's Committee as,

the Women's Committee had much more clout than the Working Group on Women's Health Policy could ever have, and it could implement policies and decisions much easier than a working group could do. (GDC Interviewee 3)

The establishment of the committee was not uniformly accepted, and opposed by two Conservative Councillors, who put forward an amendment against its establishment⁶², and later proposed its abolition in order to save the Council money⁶³. Both amendments were however rejected.

The main functions of the Women's Committee involved: granting financial assistance to women's organisations projects; supporting campaigns; and responding to external events. The Committee sought to consult with women's organisations and instructed the Head of the Women's Unit to identify appropriate organisations.⁶⁴ This process ultimately led to the establishment of the Women's Issues Group, as discussed below.

Women's Issues Group

In June 1994 the Women's Committee approved the establishment of a Women's Issues Group, following the recommendation of the Head of the Women's Unit that this would be the best way to liaise with women's organisations⁶⁵. Four Women's Committee

⁶¹Glasgow District Council (1993) *Council Meeting Minutes* (28/10/93)

⁶²Glasgow District Council (1993) *Council Meeting Minutes* (28/10/93)

⁶³Glasgow District Council (1994) *Council Special Meeting Minutes* (18/02/94)

⁶⁴Glasgow District Council (1993) *Women's Committee Minutes* (24/01/94)

⁶⁵Glasgow District Council (1994) *Women's Committee Minutes* (13/06/94)

councillors were appointed to the group.⁶⁶ This Group decided that the key issues to be addressed by the group were health issues, safety issues, women and violence and working with other Council departments. So as to not duplicate the work of other groups and organisations it was decided that the main focus of the group would be to influence District Council policy and Departments.⁶⁷

Working Group on Women's Health Policy Project Planning Group

The Project Planning Group, established in November 1995, was allocated money by the Sub-Committee on City Environment and Health to develop an information programme on women's health issues.⁶⁸ The Group developed a proposal to organise a women's health event, with the recommendation that all departments be invited to participate.⁶⁹ The agreed objectives of the event were that:

The event should attempt to raise awareness regarding 'Women's Health Policy' in general dealing with women's well-being and not just health in the context of illness. It should be educational dealing with issues raised in the document 'Glasgow's Women' and highlight the range of departmental and other services available.

The event would keep the matter of the Women's Health Policy to the fore prior to the reorganisation of Local Government in April 1996.⁷⁰

The event was held on 6th March 1996 and involved a number of other organisations outwith Council departments ⁷¹. As a result of local government reorganisation, this event proved to be the only project planned by the Group. The project based Working Group on Women's Health Policy had a greater level of departmental representation in contrast to the original group and one interviewee spoke of the positive impact of being a task-based group as "*it found a function for itself once more*" and of the willingness of people to be involved at that stage.

⁶⁶ Glasgow District Council (1994) *Women's Committee Minutes (10/10/94)*

⁶⁷ Women's Unit Papers (1994) *Women's Issues Group Meeting (18/05/94)*

⁶⁸ Glasgow District Council (1995) *Women's Committee Minutes (12/10/95)*

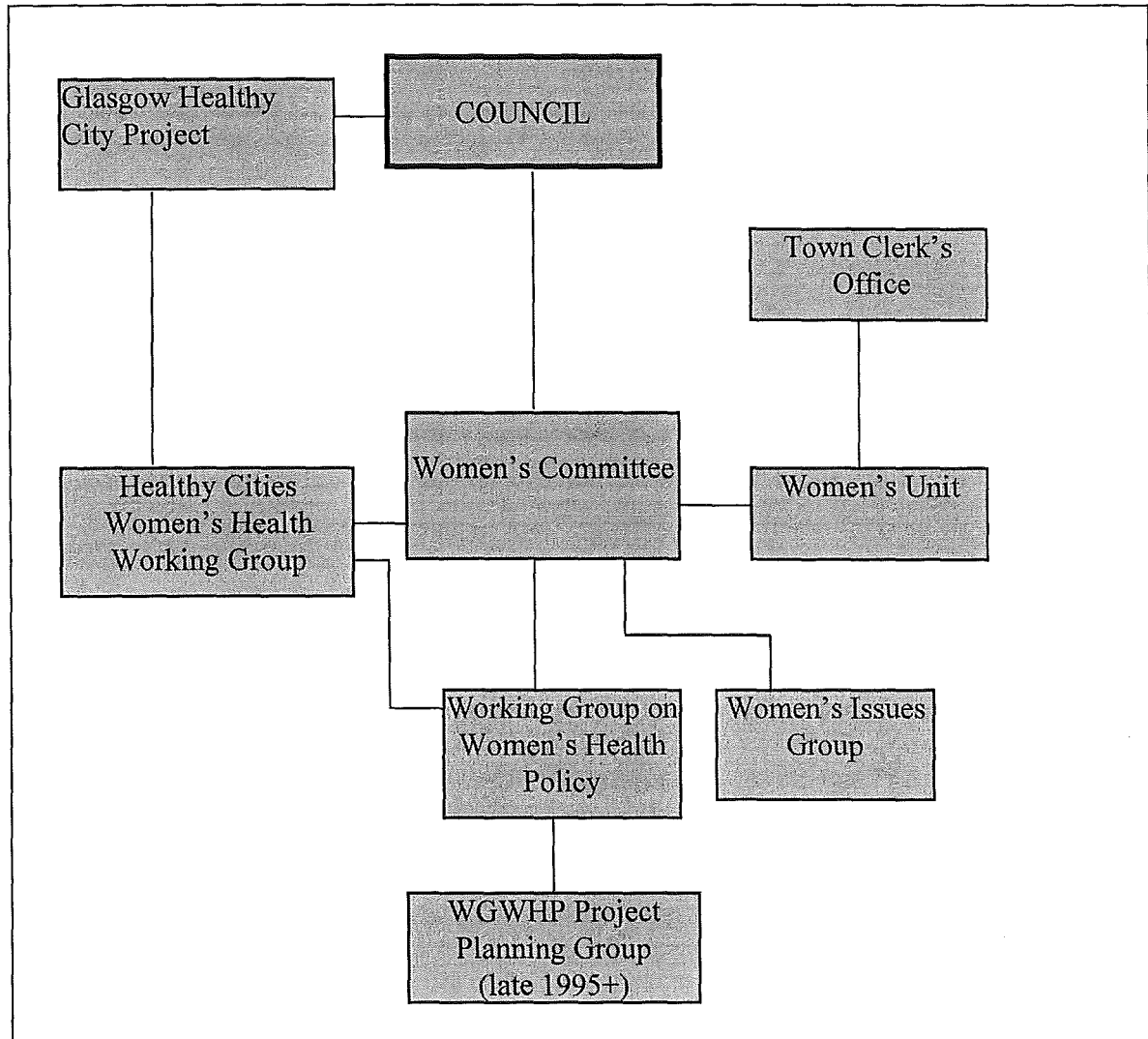
⁶⁹ Glasgow District Council (1995) *Women's Committee Minutes (12/12/95)*; GDC Policy and Resources Committee (1995) *Sub-committee in City Environment and Health Minutes (13/12/95)*

⁷⁰ GDC Women's Committee (1995) *Working Group on Women's Health Policy Minutes (21/11/95)*

⁷¹ GDC Women's Committee (1995) *Working Group on Women's Health Policy - Project Planning Group Minutes (11/01/96)*

Figure 4.6 outlines the GDC decision-making structure in relation to the Women's Health Policy after the establishment of the Women's Committee.

Figure 4.6: GDC Decision-making Structure 1994-1996



4.4.3.3 Representation

Following the establishment of the Working Group on Women's Health Policy, several departments were requested to send representatives to the Group. The departments approached were those which could be considered to have a 'traditional' link to health issues, such as Environmental Health, Housing and Personnel, where it was considered that work could be actioned. Thus the range of departments within which the Policy was introduced was limited from the outset. When this Group transformed into the Project Planning Group the range of departments represented increased, as did the consistency of

attendance of representatives. There were significant overlaps in the representatives to both the WGWHP and the Women's Committee, although membership of the Women's Committee was restricted to elected members and co-optees.

The WGWHP departmental representatives were by and large selected rather than self-nominating and ranged from chief officers to the PA to a director. Whilst to some the representatives were considered to be committed and enthusiastic, a perceived problem was the lack of strategic positioning of many these representatives to enact the work, as they occupied mainly middle management positions. Other interviewees highlighted further problems, including that of women being asked to attend because they were women rather than that they had any interest or expertise, and that the directors had little interest in the group beyond having someone who was seen to attend. Some even suggested that they deliberately chose representatives who had little power. Obviously this has implications for the ability of representatives to act as a link between the group and the departments, for information exchange and the development of work on the Policy. The senior GDC interviewees all reported that representation had been delegated to women further down their departmental structure. One interviewee commented,

I became involved because, basically the way I think most people became involved, the directors of each department were asked to send somebody... I attended, but I didn't have any involvement, and I would say that was true of most other departments. We all attended because we had to attend. It comes back to ticking off that we did actually have someone turn up. (GDC Interviewee 5)

Another interviewee also commented that involvement tended to be restricted to responding to departmental issues and requests for reports, adding that this resulted from the nature of the organisation.

I was only slightly involved in it because I would be, this is traditional local government and unless you had a particular interest in a subject, OK, you will go to a Committee and respond on housing issues but you won't look at the wider side of things because they are covered by other committees. (GDC Interviewee 6)

There were also initial problems in identifying a representative for the multi-agency Women's Health Working Group, which resulted in the lack of communication with the

WHWG. The internal working group was written to by the Glasgow Healthy City Project Co-ordinator asking them to nominate a representative ⁷².

4.4.3.4 Priorities for action

The WGWHP developed its priorities for action by consulting within departments. An initial consultation process had involved the development of a GDC composite response to the draft consultation document of the Women's Health Policy in November 1991⁷³.

Following the adoption of the Policy, consultations again took place with women employees using informal discussion groups within four departments: Housing, Libraries, Environmental Health and Town Clerk's. As a result of these consultation a range of issues were raised, grouped into the following categories:

- . **Health:** introduction of well woman/health screening; Health and Safety for VDU operators; Toxic Shock Syndrome;
- . **Personal Safety:** consideration of women at design stage, lighting, access, provision or subsidy of personal alarms, personal safety courses;
- . **Childcare/carers:** clarification of conditions of service - maternity, paternity, adoption, fertility treatment leave; extension of 'carers leave'; extension of existing childcare facility and other childcare options;
- . **Retirement/Pensions :** Equal pension rights for male and female employees; pre-retirement counselling;
- . **Miscellaneous:** clarification of role and services provided by the welfare section.⁷⁴

As can be seen these issues reflect medical/health care and personnel issues rather than service provision. These issues were adopted by the WGWHP as key areas of concern on which action needed to be taken⁷⁵. In addition, a report was prepared in November 1992 to identify which elements of the Policy were applicable to the District Council, which

⁷²Glasgow District Council Corporate Policy Development (1993) *Discussion Record* (10/02/93)

⁷³ GDC Central Policy and Research Unit (1991) *Response to 'Women's Health Policy for Glasgow - A Framework for Discussion' - Report by the Head of Corporate Policy Development* (01/11/91)

⁷⁴ GDC Central Policy and Research Unit (1993) *Departmental Discussion Groups - Issues. For the Consideration of the Working Group on Women's Health Policy.* (06/93)

⁷⁵ GDC Policy and Resources Committee (1993) *Working Group on Women's Health Policy Minutes* (25/06/93)

selected 18 of the Policy recommendations ⁷⁶. The 'Priority Issues for Action' in the Policy were considered either to have been enacted or to be currently under consideration by the WGWH, with the exception of the issue of inter-agency representation on the group.⁷⁷ The Group decided to focus on two distinct areas: firstly, issues affecting council employees; and secondly, issues relating to service delivery "*in so far as any service was directed at or utilised by women*"⁷⁸. In distinguishing between the Council's role as an employer and a service provider the WGWH decided to concentrate on the employer role in the short term for a number of reasons:

women account for approximately half of APT&C employees

the departmental discussion groups are generating clear issues related to women's health

the issues are related predominantly to their service and conditions

*the Council has an established commitment to equal opportunities policies.*⁷⁹

Some interviewees commented that the decision to focus on personnel issues was based on the belief that this was an area in which change could be achieved. Whilst developing the implications of the Policy for service delivery remained an objective of the WGWH, little or no action took place in this area. This is something which attracted a degree of criticism by some GHCP representatives

The original aim of the Policy was in a sense subverted and what should have been relatively low priority issues became relatively high priorities...they very quickly moved on to women at work and very quickly moved on to women in the District Council and very quickly moved on to themselves. It's questionable what they were doing as a professional group for women in the city in general. (GDC Interviewee 2)

Issues the Group agreed to progress were: smoking, passive smoking and the Council's no smoking policy; departmental discussion group issues; feasibility of health screening or fitness session initiatives; and women and violence.⁸⁰

⁷⁶ Refer to Women's Health Policy (Appendix 1) Recommendations: 1.1-1.5, 2.1, 2.4, 2.6, 2.9, 2.10, 3.1, 3.2, 3.4, 4.1, 4.2, 4.8, 4.9, and 4.10

⁷⁷ GDC Central Policy and Research Unit (1992) *Implementing the Policy for Women's Health - Discussion Paper for the Consideration of the Working Group on Women's Health Policy* (19/11/92)

⁷⁸ GDC Policy and Resources Committee (1992) *Working Group on Women's Health Policy* (30/11/92)

⁷⁹ GDC Central Policy and Research Unit (1993) *Women's Health Policy - Current Progress and Future Action. Discussion Paper* (05/93)

4.4.4 Strathclyde Regional Council Advisory Group on Women's Issues/Health Issues Based Group

4.4.4.1 SRC organisational structure

Strathclyde Regional Council was established as part of the 1974 local government reorganisation, and was the largest regional council in the UK, serving approximately half the population of Scotland. The Council had 104 elected members, with Labour forming the majority administration with 85/104 elected members in 1995, and 15 full committees and five divisional community development committees, plus a range of sub-committees, advisory and working groups. The main decision-making committee was the Policy and Resources Committee, through which any major policy changes or resource implications must be passed before being ratified by the Council. The Council also comprised of 25 departments. Strathclyde Regional Council was disbanded in 1996 as a result of the latest local government reorganisation and the creation of the new single-tier unitary authorities.

In contrast to GDC and GGHB, the structures through which the implementation of the Women's Health Policy was intended to be overseen within SRC were established prior to the adoption of the Policy. The Health Issues Based Group, a sub-group of the Advisory Group on Women's Issues, was given the remit to monitor the implementation of the WHP.

4.4.4.2 Structures

Advisory Group on Women's Issue's

The Advisory Group on Women's Issues (AGoWI) was established in October 1988⁸¹. Interviewees who had been involved in the discussions around the establishment of the AGoWI, noted that the pressure for such a forum to be established arose out commitment made in the Labour manifesto for the 1986 local government elections to progress women's issues. In 1987 a member/officer Equal Opportunities Working Group was established to identify the changes needed in relation to equal opportunities/women's issues

⁸⁰ GDC Policy and resources Committee (1993) *Working Group on Women's Health Policy minutes (23/05/93)*

⁸¹ Strathclyde Regional Council (1988) *Advisory Group on Women's Issues Meeting Minutes, (27/10/88)*

in relation to employees and service provision. This working group recommended the establishment of a Policy and Resources sub-committee on equal opportunities with working groups on women's issues, ethnic minorities and disability. The report noted that Regional staff had favoured the establishment of a Women's Committee and Unit, but the Working Group

was anxious however to ensure that the preferred structure did not serve to "marginalise" the issues but was an integral part of the decision-making system. The evidence from more than one authority served to illustrate the ease with which a committee could become isolated from the mainstream committee structure and become a talking shop at which a wide-range of issues were discussed without any consequent changes to either policy or practice.⁸²

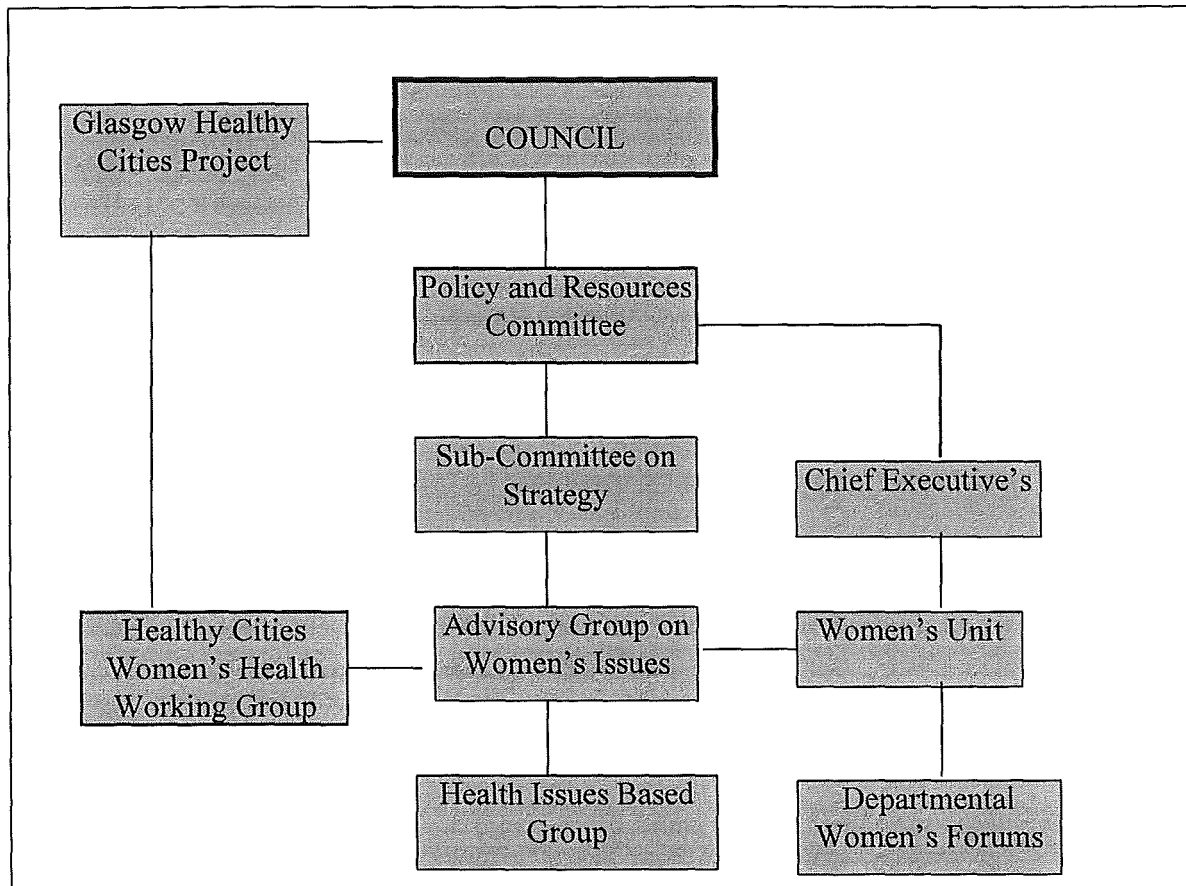
However, after consultation with departments and in light of the decision of the Policy and Resources Committee to establish an Advisory Group on Race Relations, it was decided that it would be appropriate for a similar structure to be established looking at women's issues, which would report through the Policy and Resources Sub-Committee on Strategy⁸³.

Figure 4.7 details the organisational structure through which the Women's Health Policy was intended to be implemented.

⁸²SRC Policy and Resources Committee (1987) *Member/Officer Group on Equal Opportunities - Report by Working Group* (13/11/87)

⁸³Strathclyde Regional Council (1988) *Advisory Group on Women's Issues : Membership and Terms of Reference - Report by the Chief Executive*, (06/09/88)

Figure 4.7: SRC Decision-making Structure.



The Advisory Group consisted of 14 elected members, three co-opted non-employees, and two co-opted women employees. It was also decided that a Women's Unit should be established to support the Advisory Group, comprising of a Women's Officer and administrative/clerical support, and a Women's Officer was appointed in February 1989. The Advisory Group was established with the following terms of reference:

1. Advise all committees to ensure that all policies and services have due regard to the rights, welfare and interests of women.
2. To identify the issues of concern to women and make proposals to appropriate committees for new initiatives
3. To encourage community and voluntary sector organisations to establish initiatives
4. To advise the Policy and Resources Committee on the need for representations on behalf of the Council to public agencies and government
5. To request and receive information from Council Committees and/or Chief Officers on issues relating specifically to women.
6. To provide in response to a request from any committee or Chief Officer advice on any matter specifically relating to women.⁸⁴

⁸⁴SRC (06/09/88) *ibid*.

It was decided that one in every two meetings should be held within one of the Districts to enable consultation with local women ⁸⁵.

As an Advisory Group to the Policy and Resources Committee the AGoWI should have been able to link into the decision-making process. However, the Group could only make recommendations, and reporting to the committee was infrequent. The status of the group was an issue that was returned to on occasion, but the recommendation that it should be upgraded to a full committee never became a reality. As one interviewee noted,

there were kind of mumblings about there should be a committee but I think we knew that the majority of the group didn't want to be a committee, it was quite happy to have just an advisory group. And it wasn't worth the hassle. (SRC Interviewee 10)

Interviewees involved in these groups perceived their role as being a “*political facilitator to get the political goodwill to do things*”. Interviewees also perceived the role of the groups as being to raise awareness and the profile of women’s issues within the organisation. As one interviewee noted,

our job was to sort of feel the way and let these people know, let the men who had the power in Strathclyde know the issues that were there and what we needed. (SRC Interviewee 6)

A number of priority issues were decided upon: involvement with Initiative Areas; work with girls and young women; women and the arts; women into employment; training; and health promotion.

Issue Based Groups

The identification by the AGoWI of key areas of concern led to the development in June 1989 of issue based groups to work on the particular areas: education, employment and training; childcare and dependent care; health; and networking of women’s groups/public life, later renamed ‘Women in Decision-making’. Initially these comprised of elected

⁸⁵SRC Advisory Group on Women's Issues (1990) *Advisory Group Seminar (15/08/90)*

members but in 1990 it was decided to extend the membership of these groups to include representatives from departments, voluntary organisations and other agencies.

Health Issues Based Group

The Health Issues Based Group (HIBG) appears to have been the most self-sufficient of the issue based groups, and the only one to have its minutes regularly remitted for approval of the AGoWI. It was also the group given responsibility for monitoring the implementation of the WHP. It tended to operate on a more topic-led basis, devoting particular meetings to a particular issue inviting a speaker to make a presentation. Initial topic work of the group focused on health care issues, although this later broadened to include discussions on: WHP; the Centre For Women's Health; women and violence; education; health needs of girls and young women; teenage pregnancy; health needs of older women; need for co-ordination of work and services; women in their middle years; and women's mental health.

Departmental Women's Forums

The Women's Officer tried to establish a network of women's forums within each department to enable women to discuss women's issues, and to inform the Women's Unit of issues/matters they wanted to be raised within the Advisory Group. By 1993 Women's Forums had been established in 13 departments, including Education, Social Work, Consumer and Trading Standards and Architects.⁸⁶

Key Departments/ Individuals

In addition to the Women's Officer and Unit, some departments also had staff responsible for women's issues, such as the Equal Opportunities Officer within the Education Department and a Senior Officer with a remit for women's and health issues in the Social Work Department. For some interviewees the existence of senior officers with specific remits and the formal structures provided the means of implementing the Policy.

It has worked I think where we've had active individuals who have access to Senior Officers and politicians... departmental forums and district forums which allowed access to information. It allowed us to pick up on interested individuals, but also

⁸⁶ SRC Advisory Group on Women's Issues (1993) *Women's Unit Progress Report January - March 1993 - Report by the Women's Officer (03/93)*

4.4.4.3 Representation

As local government fora, both the Advisory Group and the Health Issues Based Group comprised mainly of elected members. Both Groups had a number of external and internal co-optees, but in the main officer representation was confined to when attendance was requested to present or discuss specific issues. Thus, involvement and activity on women's health issues and the Women's Health Policy was not necessarily reflected in attendance at meetings. However through the establishment of priority issues, and the selection of co-optees (Chief Executive's, Education and Social Work), decisions were taken about what areas and departments were considered to be the most important and influential. In both the AGoWI and the HIBG, representation was from Chief Executive's, Social Work, Education and Personnel. In general the representatives to the Group were self-nominating rather than being delegated the task. However, senior officer representation was requested by the Women's Officer, although their actual attendance at the Advisory Group was largely confined to attendance at specific sessions to present departmental action plans. The only notable exceptions were an Assistant Chief Executive, and the Assistant Director of Personnel.

4.4.4.4 Priorities for Action

The priority issues of the AGoWI remained largely the same during the life of the Group and progressed through the Issue Based Groups. These included the development of a Women's Issues Policy Statement, Departmental Action Plans, and a departmental consultation on the WHP.

Women's Issues Policy Statement

Strathclyde Regional Council had introduced a formal Equal Opportunities Policy in November 1987⁸⁷. However, over time it became apparent to the AGoWI that there were examples of specific policies on women's issues within departments but that there was a need for a strong policy statement on the Council's commitment to women and equal

⁸⁷quoted in SRC Policy and Resources Committee (1991) *Women and Equality policy Statement - Report by the Chief Executive (07/10/91)*

opportunities, the need for policies and services to take account of the needs of women, and for the eradication of sexism in the formulation of policy and service delivery. In developing the idea for a statement, the Group agreed that,

The statement should illustrate the overall benefits to the Council and the general population in pursuing equal opportunities, and identify the links between issues that affect women and other specific groups, for example access for the disabled, child care for parents.⁸⁸

The Women's Officer drafted a statement for consideration by the Advisory Group and submission to the Policy and Resources Committee.

Departmental Action Plans

The Women's Officer requested departments to produce a position statement on women's issues from which action plans could be developed, addressing both personnel and service issues. She sought nominations from all departments for a contact officer with whom she could liaise and who would take responsibility for women's issues in that department. It was requested that these contact officers should be senior staff. Departmental nominations were received by the end of 1989, and seminars were organised for representatives from all departments⁸⁹.

The position statements, first requested in 1989 took a long time to materialise, and as such there was a delay in the development of action plans⁹⁰. The first seven Action Plans were presented at an Advisory group meeting in June 1991, and all had been presented by June 1992, almost three years after they were first requested. As the Women's Officer noted, many departments had experienced difficulty in drawing up the Action Plans, suggesting that

It appeared to stem from a lack of understanding of the scope of gender equality issues.⁹¹

⁸⁸Strathclyde Regional Council (1990) *Advisory Group on Women's Issues Minutes (26/09/90)*

⁸⁹ SRC Advisory Group on Women's Issues (1989) *Women's Unit Progress Report June-August 1989 - Report by Women's Officer (7/9/89)*

⁹⁰ SRC Advisory Group on Women's Issues (1990) *Advisory Group on Women's Issues and Women's Unit Progress Report November/December 1990 - Report by the Women's Officer (14/12/90)*

⁹¹ SRC Advisory Group on Women's Issues (1992) *Departmental Action Plans on Women's Issues Guidelines - Report by the Women's Officer (02/92)*

Women's Health Policy Consultation

The formal consultation of the draft Women's Health Policy began with the submission of the document for comment to the Advisory Group on Women's Issues in June 1991. A seminar was arranged for departmental nominated officers to encourage them to consult within their departments on issues for employees and services provision arising from the Policy. The draft composite response was circulated for comments to departments before being submitted to the Advisory Group in September 1991.

In September 1992 a seminar was held to review the priorities and objectives of the Group. The achievements of the Group on the priority issues were noted as follows:

Health -

Women's Health Policy (WHWG/GHCP)

Schools consultation and work with the Education Department

Proposal for CFWH

Employment and Training -

Women's Technology Centre (ESF funded)

Women's Business Start-Up Project (ESF funded)

Proposal for five Women's Business Centres (ERDF/UP)

Women and Public Life -

Public Life Pilot Dumbarton

Assertiveness Packs

Training Courses for assertiveness trainers

Production of Video "Making it Work for Women"⁹²

Following the departmental consultations the Women's Officer drew up a report on departmental responses⁹³. Common issues identified by the departments included the need for:

- 1. Childcare provision - workplace nurseries and after-school care*
- 2. In-house health screening facilities - Well Woman clinics and mobile health units*
- 3. Improved hygiene facilities*
- 4. Improved conditions of service - maternity/special leave, flexible working*
- 5. Improved information on existing health care provision*
- 6. Initiatives to further Health and Safety*

⁹² SRC Advisory Group on Women's Issues (1992) *Advisory Group Seminar (02/09/92)*

⁹³ SRC Advisory Group on Women's Issues (1993) *Women's Health Policy : Departmental Responses - Report by the Women's Officer (08/93)*

7. Initiatives to further awareness of women's health issues - changing attitudes, training
8. Improvements in council accommodation. - access⁹⁴

As can be seen, issues highlighted by the departments largely concerned health care and personnel issues. This was acknowledged by the Women's Officer who commented on the areas that had been neglected by departments, For example:

responses focused on staffing issues with little mention of service delivery... lack of knowledge of how services might affect different women in different ways... This appears to be a question of lack of awareness of equality issues in general and could be addressed via departmental women's groups where they exist ... In general, a rather 'sanitised' picture of women's health was presented and more problematic or controversial areas were not considered. ⁹⁵

The following year departments were asked to produce progress reports on action undertaken in relation to the WHP⁹⁶. Several departments had not provided reports and in a composite report by the Women's Officer it was noted that

Of those departments which had responded, with the exception of the Department of Consumer and Trading Standards, there had been given an impression of a lack of commitment to address key issues; and some department's comments lacked clarity and did not quantify what steps had been taken to address the issues⁹⁷

As a result of this lack of action additional information was requested from the Directors of departments. The monitoring report should have been completed January 1995, but no report was located.

4.5 Discussion

Within this chapter, the influences and events leading to the development of action on women's health in Glasgow, and the Women's Health Policy in particular, have been

⁹⁴ SRC Advisory Group on Women's Issues (1993) Women's Health Policy : Departmental Responses - Report by the Women's Officer (08/93)

⁹⁵ SRC Advisory Group on Women's Issues (1993) Women's Health Policy : Departmental Responses - Report by the Women's Officer (08/93)

⁹⁶ SRC Advisory group on Women's Issues (1994) Women's Health Policy Monitoring Report - Report by the Women's Officer (22/9/94)

⁹⁷ SRC Advisory group on Women's Issues (1994) Women's Health Policy Monitoring Report - Report by the Women's Officer (22/9/94)

reviewed. Debates on 'health' have a long history in Glasgow, and have been conducted within a changing configuration of groups. These groups have invariably contained members from different organisational and professional backgrounds, and as such, it may be argued that there has been an established multi-agency focus to debates on health. These groups had a number of key members who have been involved over the years, and indeed common membership of each of the groups (Politics of Health/Clydeside Women's Health Campaign/Glasgow Healthy Cities Project/Women's Health Working Group) has been identified.

However the concept of health developed within each of these groups varied. Whilst the Clydeside Women's Health Campaign, in its stated aims and Women's Health Charter, could be said to have a bio-medical and health care focus, the Politics of Health Group highlighted the need to put health as opposed to ill-health on the political agenda, using a structural concept which identified the impact of class and poverty on health. This concept bears a close resemblance to that contained within the Healthy Cities Project, which promoted a positive, holistic concept of health, emphasising the integrated influences of economic, environmental and social spheres and the need to take a multi-sectoral approach, including community participation. With the establishment of the Women's Health Working Group, the focus of health broadened from that of its predecessor, the Clydeside Women's Health Campaign, to present a social model of health, highlighting the impact of women's social and reproductive roles on their health. However, the focus of the Women's Health Policy has retained some of the objectives of the Clydeside Women's Health Campaign, particularly within Objective 4, by seeking to provide women-specific services and support, and identifying a range of primarily health care targets.

Thus, whilst a common thread can be identified in the approach to health of all these groups the nuances demonstrate competing influences and interpretations, particularly between the GHCP and its WHWG. More specifically, whilst the GHCP can be seen to be related to the new public health movement, the trajectory of the WHWG and the WHP resembles that of the women's health movement. The developments relating to women's health in Glasgow closely resemble Doyal's (1983) analysis of the stages in the women's health movement: moving from a focus on women's biology, to seeking changes within the

system, notably the NHS, to the advocacy for a social model of health. The impact of this in relation to the implementation of the Policy will be discussed further in subsequent chapters.

In reviewing the development of action on women's health in Glasgow, it is clear that this has been a 'bottom up' approach. Whilst the action has always been led by women working within the statutory sector organisations, and in particular GGHB, its development has been from a position 'outside' the policy and decision-making structures of their organisations. The development of multi-agency action within the CWHC and the WHWG can be seen as voluntary (that is, neither directed by legislation or incentives (Hudson, 1997), with a recognition of the shared concerns, and the 'collaborative advantage' to be gained (Huxham, 1996). Whilst these initiatives were initially informal, over time they became more formalised as priorities were established and structures defined, but they remained without statutory requirement or incentive motivations (see Hudson, 1997).

The WHP itself was developed by the multi-agency WHWG in consultation with a range of organisations and women in the community. The idea for the development of a policy followed years of sustained campaigning by the CWHC seeking to promote action on women's health, and was intended to act as a lever to promote change in organisations. The development process of the Policy can be characterised as 'bottom up', and accounts emphasise the attempts to make the development of the Policy participatory and inclusive of the needs of all women.

The model of policy making associated with the WHP, developed collectively by women from a variety of backgrounds, from a position outwith the formal authority structures of the organisations, fits uncomfortably with traditional models of policy making. As has been discussed in Chapter 2, such models generally presume that policies are made centrally by 'experts' in positions of power. This may be seen to derive from the origins of policy studies in political science, and an emphasis on government and legislation. However, the Policy arguably contains elements relating both to the traditional rational and incremental models of policy making: 'rational' in the sense that it contains long term 'ideal type' goals, such as improving the health and well-being of women; and

‘incremental’ in that it has a series of short term targets that are based on small step changes from the status quo. In addition, the development of the WHP through processes of consultation involving negotiation with a broad range of actors suggests a ‘strategic incrementalist’ approach.

The ‘Implementation Structure Approach’ of Hjern and Porter (1981) provides a useful framework for considering the implementation process of the WHP. The partner agencies of the GHCP can be conceived of as the intended implementation structure, with the ‘units of purposive action’ being the WHWG and the organisational women’s fora. The structure can be characterised as one of low cohesiveness, being a largely voluntary arrangement with limited agreement on expected roles and action. This model also highlights the significance of interests and power differentials in the implementation process, in contrast to the presumed rationality and objectivity of top-down models. As will be demonstrated in the forthcoming analysis, differences in power and interests have been characterised as being substantial influences on the implementation of the WHP.

In relation to content, the WHP is based on a homogenised view of the needs of women, and contains a combination of tangible and intangible elements. Tangible examples include the development of the Centre for Women's Health and calls for the improvements in the delivery and availability of services. Less tangible elements include the improvements of relationships between organisations in policy development and implementation. The recommendations for action broadly centre on improving women’s access to decision-making and addressing the barriers to their participation. The need to raise awareness of women’s health needs and developing understanding at senior levels are highlighted, in addition to particular service recommendations. In comparison to the gender inclusion strategies discussed in Chapter 2, the Policy contains aspects of positive action and mainstreaming approaches. For example, flexible hours for workers and service users (Recommendation 2.10) as positive action; and incorporating gender issues into all local strategy documents (Recommendation 2.1) as mainstreaming.

The CWHC and the WHWG both sought to develop strategies to ensure the implementation of their aims, and pursued various opportunities as they arose. The

WHWG encountered difficulties in working collaboratively, and securing organisational support and representation, mirroring problems reported in the development of the Women's Health Fair. Nevertheless, it is important to note that the focus for action was always to create change within the existing system, rather than to establish alternative provision. This may be seen as resulting both from a reluctance to challenge the statutory provision of services within the welfare state and being seen to promote private provision, as argued by Doyal (1983) in relation to the British women's health movement. In this context, the membership of the GHCP may have provided a significant opportunity for the informal lobbying already taking place outside the organisations to become more formalised within the decision-making structures of the organisations. This undoubtedly had a significant impact in enabling the development and adoption of the WHP and the realisation of the long campaigned for Centre for Women's Health.

In relation to the implementation of the WHP, it is clear that the WHWG sought to develop a programme of action, and develop work on particular themes and issues through its subgroups. However, there appears to have been a tension between the desire to be inclusive and participatory, and the desire to 'make things happen'. For example, the lack of representation of women in the community was a recurring issue, yet one which was never adequately resolved. In contrast, efforts were continually being made to seek strategic representation within the organisations. In addition, representation from individual voluntary sector organisations lacked continuity, and the WHWG remained dominated by GGHB members.

A number of contrasts can be identified between the WHWG and the organisational women's fora, and indeed between these organisational fora. As has previously been highlighted, the WHWG was, initially at least, a voluntary multi-agency forum which aimed to be open and participatory. In contrast, the organisational women's fora within each of the organisations had been created rather than evolving within these organisations. As such, membership of the WHWG was more often based on the interest and commitment of members than the organisational women's fora where some representatives were less positive about their involvement. This lack of interest or commitment was perhaps reflected in the difficulties experienced in securing interviews with GDC departmental

representatives, as discussed in Chapter 3 on Research Methods and Design. In addition, whereas the WHWG was a multi-agency group, seeking action across organisations, the organisational fora were intra-organisational. This issue is discussed further in Chapter 6.

In relation to the organisational women's fora, the grounds for the development of the two local authority women's fora lay within Labour Party manifesto pledges to promote women's issues. Within the SRC these structures had been established prior to the launch of the WHP, whilst in GDC the Policy was credited by some as assisting this pledge become a reality. Whilst the GDC Women's Committee was unique in terms of these fora having a budget, it also clear that such structures were not universally supported within the organisation. A clear difference between the local authority and GGHB fora is that whilst the former largely consisted of councillors, the GGHB fora were officer led. Whether this had any impact on the implementation of the Policy within the organisations will be discussed further in subsequent chapters.

Following the establishment of these fora to oversee the implementation of the Policy, each of the fora sought to identify their own priorities for action. The GGHB fora adopted all of the Policy recommendations and established six priorities which included service development and the inclusion of women's health in purchasing and planning. In GDC, the priorities were developed following a consultation exercise with a selected range of departments. A review of the Policy also highlighted 18 of the 34 recommendations as applicable to the GDC; however the WGWHF focused on the issues raised by the departments, which were largely on personnel issues, and took a narrow medical or health care view of health.

Within SRC, the women's fora had an established record of developing action and strategies relating to the promotion of gender equality, for example developing pilot programmes on assertiveness training, and employment issues. The method by which the WHP was introduced into the organisation involved a consultation exercise, and seeking implementation within departments through the development of departmental action plans and requests for progress reports. The framework of activity of the SRC Advisory Group on Women's Issues relates closely to the contents of the Women's Health Policy.

However, 'health' as an issue was dealt with separately within the Health Issue Based Group which arguably broke the cognitive link between the two groups. The Health Issues Based Group was formed prior to the adoption of the Women's Health Policy and focused largely on 'traditional' health issues. The remitting of the WHP to this group arguably illustrated and amplified a misunderstanding of the WHP. Similarly, the fact that departmental action plans were requested prior to action plans on women's health perhaps meant that the links between the two issues were not understood, and resulted in a focus in health care and personnel issues.

4.6 Summary

This chapter has reviewed the establishment of action on women's health in Glasgow, in particular the development of the Women's Health Policy and its implementation with statutory sector organisations. A number of issues have been raised relating to representation, organisational support and understandings of health that appear to have shaped the direction of action and the scope for multi-agency working and implementation of the WHP within the organisations. The enabling and hindering effects of these factors will be explored within the coming chapters. Firstly, within Chapter 5, the enablers to this process are explored.

Chapter 5 - Implementing the Glasgow Women's Health Policy: Action and Enablers

5.1 Introduction

Following the establishment of the Women's Health Working Group and the development of the Glasgow Women's Health Policy, a range of action for women's health took place within the statutory sector partner organisations. The direction and focus of the work in Glasgow, and the types of action that ensued will have been influenced by the context, social, economic, structural and cultural, within which the Policy was introduced. In order to understand this context and processes, this chapter reviews the action that took place, and explores the interviewees' perceptions of the factors or circumstances that acted as enablers to the implementation of the Policy within the statutory sector organisations.

It should be noted at the outset that many interviewees, particularly those who had been selected for interview on the basis of their senior, strategic position within their organisations, but also many members of the organisational women's fora, felt unable to comment in detail about the implementation process, and more specifically what action had taken place in relation to the Women's Health Policy. This issue will be explored further in Chapter 6. However, most interviewees felt able to comment on what they considered to have been the enablers within the process. Following a review of action in relation to the WHP, the interviewees' perceptions of the factors which have supported the implementation are explored. This is followed by a discussion, firstly, of the interviewees' views of the strategy of having a separate policy for women's health, and secondly of the benefits and enablers of multi-agency working.

5.2 Glasgow Women's Health Policy: Examples of action

This section draws together some of the key aspects of action which exemplify the implementation of the WHP. Perhaps the most significant of these has been the establishment of the jointly-funded Centre for Women's Health. Other examples of action

include: monitoring implementation; research and information; awareness raising, training, seminars and events; responding to policies; service development; and the European MCAP. Each will be discussed in turn.

5.2.1 Centre for Women's Health

The establishment of the Centre for Women's Health can perhaps be regarded as the pinnacle of the achievements associated with the Women's Health Policy during this period. However, it must be emphasised that whilst the establishment of a Centre for Women's Health was contained within the Policy as a 'Priority for Action', the idea for a centre had been in development for a number of years previously. Indeed, the idea of establishing a central Well Woman Centre emerged from the 1983 Women's Health Fair, and lobbying for a Centre was started by the Clydeside Women's Health Campaign in 1985⁹⁸, before being continued by the Women's Health Working Group. Nevertheless this may be considered the primary example of multi-agency commitment to promoting women's health in Glasgow.

During the development stage and lobbying for a Centre, there were a range of differing ideas about the form it should take. Discussions were informed by information collected at visits to similar initiatives in Boston (USA) and Calderdale (UK Yorkshire). The Group was however agreed on the need to secure adequate funding, as one interviewee commented,

the one thing we'd always been determined about was that it was going to be a properly funded centre. We didn't want something where we were going to have to be looking for money every year, going around trying to get grants. So we wanted it funded by the Health Board, the District and the Region. (GGHB Interviewee 8)

Whilst lobbying for funding and support, firmer proposals about what a women's health centre would offer were being developed. In 1989, the renamed Women's Health Action Group prepared a two page draft of the aims of the Centre, and developed a list of required staff and job descriptions⁹⁹. Later, members of the Women's Health Working Group

⁹⁸ Clydeside Women's Health Campaign (1986) *Minutes 11/03/86* (Glasgow: Clydeside Women's Health Campaign)

⁹⁹ Clydeside Women's Health Campaign (1989) *Minutes 14/02/89* (Glasgow: Clydeside Women's Health Campaign)

agreed that the Centre for Women's Health would include both outreach and drop-in services, and act as a training point and a model of good practice¹⁰⁰. The aims of the Centre, as outlined in a draft proposal, were:

1. *to provide a health promotion service which responds to the unmet needs of all women*
2. *to provide a training centre for staff and lay workers in order to increase their understanding and practice of women's health*
3. *to assess the feasibility of existing services to encompass the model of inter-agency practice in the provision of health*¹⁰¹.

A number of possible sites for the proposed centre were considered, including one site that was rejected due to a concern that the centre may become too closely associated with the Family Planning Association¹⁰². By April 1992 the Eye Infirmary in Sandyford Place was being offered as a possible site.

Initially, GGHB was the focus for lobbying by the Well Woman campaign group, who requested updates on the progression of proposals¹⁰³; organised a petition which was presented to the Board¹⁰⁴; and held a 'Well Woman afternoon' to demonstrate the type of facility the Campaign Group had been pressurising the Health Board to support¹⁰⁵.

Responses to the letters by the Chair of the Health Board generally suggested that whilst there was an acceptance to the idea for a Centre in principle, other priorities had to be dealt with¹⁰⁶. An interviewee commented in relation to this process,

The proposal for the centre I gave to my colleagues here and it was absolutely turned down flat, there was no support apart from (two workers) pushing it in Health Promotion. Then it kind of went up and down, but nothing much happened. (GGHB Interviewee 4)

¹⁰⁰ Women's Health Working Group (1990) *Minutes 06/06/90* (Glasgow: Women's Health Working Group)

¹⁰¹ Women's Health Working Group (1992) *Minutes 07/01/92* (Glasgow: Women's Health Working Group)

¹⁰² Women's Health Working Group (1991) *Minutes 03/09/91* (Glasgow: Women's Health Working Group)

¹⁰³ Clydeside Women's Health Campaign (1987) Letter to T.J. Thompson, GGHB, 03/09/87; Clydeside Women's Health Campaign (1990) Letter from Susan Gibb to Gill McIlwaine 12/01/90; Clydeside Women's Health Campaign (1990) Letter from Susan Gibb to L. Peterkin, GGHB 09/90; Clydeside Women's Health Campaign (1990) Letter from Susan Gibb to T. J. Thompson, GGHB 17/09/90

¹⁰⁴ Clydeside Women's Health Campaign (1987) Letter to T.J. Thompson, GGHB, 03/09/87

¹⁰⁵ Clydeside Women's Health Campaign (1988) Letter to members 01/02/88 (Glasgow: Clydeside Women's Health Campaign)

¹⁰⁶ Thompson, T.J. (1987) Letter to Clydeside Women's Health Campaign 08/09/87

The establishment of the Glasgow Healthy City Project in 1988 provided an additional avenue for lobbying, and in March 1989 presentations were made to both the GHCP Steering and Planning Groups, with the Campaign Group agreeing to apply pressure on the GHCP to support the proposals¹⁰⁷. By January 1990 it was reported that the GHCP had adopted the idea of the development of a Centre for Women's Health¹⁰⁸, and in June 1991 GGHB indicated that the Centre for Women's Health proposal was in line with their strategy for women and health ¹⁰⁹.

A number of interviewees commented on the change in outlook which developed as the Clydeside Women's Health Campaign group developed into the Women's Health Working Group. Having noted previous difficulties obtaining funding and accommodation, one interviewee commented that

It was only once we met Susan Baird who was then the Lord Provost, and she was quite interested, and she took on Chairing a multi-disciplinary group of workers, and all of a sudden things began to look up. (GGHB Interviewee 4)

Possibilities for funding included discussions with the GGHB over Endowment Monies of the Royal Samaritan Women's Hospital, and an Urban Aid Funding Application¹¹⁰. A meeting of representatives of GGHB, GDC and SRC to discuss funding for the Centre took place in November 1991, with the partner agencies reported to have agreed to an 'option appraisal' of whether the Centre should be located in the city centre, an Area of Priority Treatment, be an 'option facility' or a 'shop front'. The Group agreed that a city centre site would be the preferred option¹¹¹. In addition the Women's Health Working Group argued that the Centre should have its own front-door and identity, public transport access and the involvement of all of the statutory agencies¹¹².

¹⁰⁷ Clydeside Women's Health Campaign (1989) *Minutes 14/03/89* (Glasgow: Clydeside Women's Health Campaign); Clydeside Women's Health Campaign (1989) *Minutes 11/04/89* (Glasgow: Clydeside Women's Health Campaign)

¹⁰⁸ Clydeside Women's Health Campaign (1990) *Letter from Gill McIlwaine to Susan Gibb 08/01/90*

¹⁰⁹ Clydeside Women's Health Campaign (1991) *Letter to members June 1991* (Glasgow: Clydeside Women's Health Campaign)

¹¹⁰ Women's Health Working Group (1990) *Minutes 07/08/90* (Glasgow: Women's Health Working Group)

¹¹¹ Women's Health Working Group (1991) *Minutes 03/12/91* (Glasgow: Women's Health Working Group)

¹¹² Women's Health Working Group (1992) *Minutes 04/02/92* (Glasgow: Women's Health Working Group)

An application for EC funding in April 1992¹¹³ created a significant turning point in the development of the Centre for Women's Health. This application required the statutory partner organisations to state their commitment to the establishment of the Centre, and agree to provide 'matched funding'. The fifth draft of the proposal was presented to the GHCP Steering Group in March 1992, where agreement was given in principle. Following this meeting, the WHWG noted that there appeared to be strong commitment to the proposal from all three agencies, and that funding would be granted for three years initially¹¹⁴.

Following the submission of the EC funding application action relating to the Centre proposal increased. Staffing for the centre was discussed by the Group, with the proposal to have a manager, a development worker, an information worker and support staff. It was thought that these staff would be seconded from the partner agencies and reported that this had been accepted in principle by the partners¹¹⁵. By May 1992 it had been indicated to the Women's Health Working Group that the EC funding application had not been successful. The Group agreed to press on with the proposals, to try again locally for funding and to look for alternative sites. The possibility of using private funds or trust money were raised, as were other methods of fund-raising¹¹⁶.

However indirectly, the EC proposal proved to be an effective strategy; because the statutory partner agencies had pledged their commitment to the need for a Centre as part of the application, it became a project they had to fulfil. In August 1992 it was reported that Greater Glasgow Health Board had set aside £100 000 for the possible development of the Centre for Women's Health in the Eye Infirmary, contingent on co-operation from Glasgow District Council and Strathclyde Regional Council¹¹⁷. Funding for the Centre was finally agreed in March 1993.

¹¹³ Women's Health Working Group (1992) *Minutes 07/04/92* (Glasgow: Women's Health Working Group)

¹¹⁴ Women's Health Working Group (1992) *Minutes 03/03/92* (Glasgow: Women's Health Working Group)

¹¹⁵ Women's Health Working Group (1992) *Minutes 07/04/92* (Glasgow: Women's Health Working Group)

¹¹⁶ Women's Health Working Group (1992) *Minutes 12/05/92* (Glasgow: Women's Health Working Group)

¹¹⁷ Women's Health Working Group (1992) *Minutes 04/08/92* (Glasgow: Women's Health Working Group)

Issues discussed in relation to the operation of the Centre included the use of unpaid volunteers and male access to the Centre. It was agreed that appropriately trained unpaid staff would be used in the Centre, and that the Centre would provide a women-only service on the days when it was open to the public, but that men could use the Centre for training purposes¹¹⁸. One problem identified was the issue of confidentiality for service users due to the different codes of practice within the partner organisations¹¹⁹. The Women's Health Working Group was also concerned that communication should be maintained between the Working Group and the Centre management and staff; as such the Centre Co-ordinator was invited to attend Working Group meetings¹²⁰.

The Centre finally opened on 29th March 1995 at the Eye Infirmary, Sandyford Place¹²¹. Funding by the partner agencies was in the following ratio: Greater Glasgow Health Board 45%, Strathclyde Regional Council 35%, and Glasgow District Council 20%.¹²² An evaluation of the Centre was conducted between May and August 1995 to monitor its use by different clients and for what purposes¹²³. Following local government reorganisation the Centre for Women's Health continued to be funded by the two remaining partner agencies. Since the end of the period of analysis the Centre for Women's Health has continued to operate and is now part of the Sandyford Initiative, in which family planning services have moved into part of the same building.

5.2.2 Monitoring Implementation

Following the launch of the Policy 'partner updates' became a standing agenda item at Women's Health Working Group meetings. These were intended to be a means of monitoring developments and to ensuring that the activities and progress being made within the Partner agencies were communicated to members of the Women's Health

¹¹⁸ Women's Health Working Group (1993) *Minutes 06/04/93* (Glasgow: Women's Health Working Group)

¹¹⁹ Women's Health Working Group (1993) *Minutes 02/03/93* (Glasgow: Women's Health Working Group)

¹²⁰ Women's Health Working Group (1993) *Minutes 02/11/93* (Glasgow: Women's Health Working Group)

¹²¹ Women's Health Working Group (1995) *Minutes 07/02/95* (Glasgow: Women's Health Working Group)

¹²² Urquhart, A. & Reid, M. (1995) *Evaluation of the Centre for Women's Health* (Glasgow: Centre for Housing Research and Urban Studies)

¹²³ Urquhart, A. & Reid, M. (1995) *Evaluation of the Centre for Women's Health* (Glasgow: Centre for Housing Research and Urban Studies)

Working Group¹²⁴. In addition, they acted as a means by which the partner representatives could bring other policy proposals or decisions or events to the Group's attention.

However, of the statutory partner agencies, reports on progress were frequently unavailable from GDC.

On a number of occasions, WHWG members expressed concern about the limited amount of progress that had been made in relation to the Policy within the partner agencies. This led to attempts to commission an independent evaluation of the Women's Health Policy in January 1995¹²⁵, to be funded by the Glasgow Healthy City Project Steering Group¹²⁶.

Several attempts were made to secure a number of University contacts to conduct an evaluation throughout 1994 and early 1995 but without success¹²⁷. By June 1995 however, it was reported that funding for this PhD project had been obtained and the quest for an evaluation was abandoned¹²⁸.

5.2.3 Research and Information

One of the primary areas of activity undertaken by the WHWG was the production of research and information on a variety of issues relating to women's health. Examples of reports and information produced include: a 'Glasgow Women's Health Directory' of local services, produced in conjunction with Glasgow University¹²⁹; *Glasgow's Health Women Count*, a report on women's health status and needs, funded by GGHB¹³⁰; "Barriers to Health", a report on the health needs of black and ethnic minority women¹³¹; and "Disabled Women's Health in Glasgow", a report developed by the Disabled Women's sub-group after holding a series of 'roadshows' to consult with disabled women about their health needs¹³². In addition a video designed to show "women's health positively" was produced

¹²⁴ Women's Health Working Group (1992) *Minutes 07/07/92* (Glasgow: Women's Health Working Group)

¹²⁵ Women's Health Working Group (1995) *Minutes 10/01/95* (Glasgow: Women's Health Working Group)

¹²⁶ Women's Health Working Group (1994) *Minutes 05/04/94* (Glasgow: Women's Health Working Group)

¹²⁷ Women's Health Working Group (1995) *Minutes 29/03/95* (Glasgow: Women's Health Working Group)

¹²⁸ Women's Health Working Group (1995) *Minutes 06/06/95* (Glasgow: Women's Health Working Group)

¹²⁹ Women's Health Working Group (1993) *Minutes 02/11/93* (Glasgow: Women's Health Working Group)

¹³⁰ Women's Health Working Group (1994) *Minutes 03/05/94* (Glasgow: Women's Health Working Group)

¹³¹ Women's Health Working Group (1995) *Minutes 07/02/95* (Glasgow: Women's Health Working Group)

¹³² Women's Health Working Group (1996) *Minutes 05/03/96* (Glasgow: Women's Health Working Group)

in 1995¹³³, and a series of quarterly bulletins on the work of the WHWG were produced aiming to disseminate information on the activity of the Group¹³⁴. Towards the end of the period of analysis the "Action for Women's Health" or 'Action Pack' was developed with the intention of offering guidance to organisations on how to implement the WHP, which was launched in conjunction with Phase 2 of the WHP in 1996¹³⁵.

Within GGHB, members of the WHPWG were instrumental in the establishment of a development of research projects in collaboration with the NHS Trusts, such as a pilot domestic violence project to analyse women's attendance rates at an Accident and Emergency department in 1993¹³⁶, and a survey of staff health needs relating to workplace stress in 1994. In addition a research assistant was appointed to the Women's Health Team to collect base-line data on domestic violence in 1995, and members were involved in the development of the Scottish Health Needs Assessment Programme (SNAP) protocols for domestic violence within the NHS. The Health Promotion Department developed the "Women Talking" 'mini-mag' series, which involved the organisation of focus groups to discuss a range of health issues from a lay perspective, such as smoking, health disease, food and alcohol. In addition the Women's Health Team began to prepare research data by sex and gender.

At GDC, the Women's Unit produced a profile of statistical information on Glasgow's women; a leaflet detailing the functions of the Women's Committee and the Women's Unit¹³⁷; and a further leaflet giving the addresses and purposes of various organisations in Glasgow for women in need of assistance in late 1994¹³⁸. In addition the Women's Committee also allocated funding to a number of publications on violence against women, women and drugs, and an information card for the Centre for Women's Health. The Women's Committee also commissioned a research report on women and safety in Glasgow in 1994¹³⁹.

¹³³ Women's Health Working Group (1995) *Minutes 07/03/95* (Glasgow: Women's Health Working Group)

¹³⁴ Women's Health Working Group (1995) *Minutes 07/03/95* (Glasgow: Women's Health Working Group)

¹³⁵ Women's Health Working Group (1996) *Minutes 04/07/96* (Glasgow: Women's Health Working Group)

¹³⁶ GGHB (1993) *Women's Health Policy Working Group Minutes (15/12/93)*

¹³⁷ Glasgow District Council (1993) *Women's Committee Minutes (21/03/94)*

¹³⁸ Glasgow District Council (1994) *Women's Committee Minutes (10/10/94)*

¹³⁹ Glasgow District Council (1995) *Women's Committee Minutes (12/06/95)*

5.2.4 Awareness Raising, Training, Seminars and Events

Awareness raising within organisations and communities was one of the key activities all of the fora engaged in. Prior to the development of the WHP, the Women's Health Working Group sought to develop a Health for All women's event and a series of seminars on issues such as addiction, women's aid and counselling, girl's health, mental health, disability, and race. The Women's Health event was planned for October 1990 and was intended to showcase the Women's Health Policy, with workshops on leisure and recreation, women and work, women and well-being, self-help, and counselling¹⁴⁰. Difficulty was experienced in obtaining funding from the GHCP Steering Group and the partner agencies and the event was postponed until Spring 1991¹⁴¹. This event eventually was transformed into the launch of the Draft Women's Health Policy.

Following the launch of the Policy in 1992 a series of seminars and events were organised by WHWG members to raise awareness of the Women's Health Policy. Four seminars were organised for community health workers in 1992¹⁴², and the launch of the Policy to the voluntary sector and community groups took place in March 1993¹⁴³. Following this, ten community seminars were held in different locations throughout the city to raise awareness of the WHP and the CFWH¹⁴⁴. In 1995 the Black and Ethnic Minority subgroup organised a black and ethnic minority women's health conference, and the WHWG organised an Women and Health MCAP event in June 1995, focusing on the issue of women's mental health (see Section 5.2.7)¹⁴⁵.

Within GGHB, a series of awareness raising seminars were held for GGHB employees, beginning with community nurses in 1993, "*to make them more aware of the Policy and how to get it across to their clients*"¹⁴⁶. Local seminars on the WHP were organised in

¹⁴⁰ Women's Health Working Group (1990) *Minutes 07/08/90* (Glasgow: Women's Health Working Group)

¹⁴¹ Women's Health Working Group (1990) *Minutes 30/08/90* (Glasgow: Women's Health Working Group)

¹⁴² Women's Health Working Group (1992) *Minutes 06/10/92* (Glasgow: Women's Health Working Group)

¹⁴³ Women's Health Working Group (1993) *Minutes 06/04/93* (Glasgow: Women's Health Working Group)

¹⁴⁴ Women's Health Working Group (1994) *Minutes 11/01/94* (Glasgow: Women's Health Working Group)

¹⁴⁵ Women's Health Working Group (1995) *Minutes 06/06/95* (Glasgow: Women's Health Working Group)

¹⁴⁶ GGHB (1993) *Women's Health Policy Working Group Minutes (11/03/93)*

communities by the Health Promotion Department¹⁴⁷, and seminars on the Policy were also held in a number of Units or Trusts during 1994, some of which were reported to be useful but 'poorly attended'¹⁴⁸. Despite requests made by the WHPWG, awareness raising seminars were not organised at all of the Trusts, and as such an alternative strategy of holding WHPWG meetings at Trust sites, with the requirement that the host Trust make presentations on work in connection to the WHP, was established in early 1996.

In GDC, a seminar was organised on the Women's Health Policy in March 1993, by the Working Group on Women's Health Policy for District Council employees, with each department requested to nominate two members of staff to attend. Following this event, discussions began about the possibility of holding training sessions for senior managers¹⁴⁹. The approval of the Town Clerk was sought, who responded negatively to the proposal, citing the following reasons: that departmental representatives had recently attended seminars and the Directors may wish to wait and see the developments of those; that a two hour session was too long; and the pressing issue of local government reorganisation taking much time for discussion.¹⁵⁰ He also stated,

*I do think there is a danger at this stage that over-concentration on the issue will have a negative effect... On balance, therefore, I consider the proposed session to be a bad idea ... on the basis that limited steps forward at this stage are a better option than a full blown seminar. If the latter is required, then in my view it is at least a number of months from now.*¹⁵¹

The plans for the seminar were abandoned.

Additional events were organised by GDC for International Women's Day, including the launch of the Zero Tolerance Campaign, and the women's health event organised by the GWHP Project Planning Group. A series of 'Work-Out Weeks' – fitness sessions for council employees- were also organised by the Parks and Recreation Women in Sport Unit.

¹⁴⁷ GGHB (1993) *Women's Health Policy Working Group Minutes (18/08/93)*

¹⁴⁸ GGHB (1994) *Women's Health Policy Working Group Minutes (21/04/94)*

¹⁴⁹ GDC Personnel Department (1993) *Women's Health Policy Training - Preliminary Discussion Paper (17/03/93)*

¹⁵⁰ GDC Town Clerk's Office (1993) *Memorandum for Mr Andrew Lyon, Healthy Cities Co-ordinator, From Tom Monaghan, Town Clerk and Chief Executive (07/05/93)*

In SRC, training sessions and seminars were the main means by which the Women's Unit tried to progress action on gender equality issues and the Women's Health Policy within departments. They took place at various stages: within the consultation periods, in the development of action plans, and the identification of issues to be pursued. Positive Action/Gender Awareness Training programmes were developed for key groups in the Region: members of women's forums; departmental contact officers, Chairs of committees; and Heads of Departments.¹⁵²

Immediately after the official launch, a seminar was arranged for SRC Departmental Representatives in order to develop a programme of action on the Women's Health Policy, and a newsletter drafted for dissemination to departments highlighting statistics and facts about women's health¹⁵³. Two representatives were invited from each department who were asked to consult with their departments and produce departmental responses by the end of the year so that a Regional Action Plan could be produced¹⁵⁴. A further seminar took place for community education and community work staff, and staff from women's projects and initiative areas in February 1993 to enlist their support for the community launch of the Policy in March 1993. In addition to informing and involving workers in the implementation of the Policy the intention was also to encourage workers to discuss the Policy with local women¹⁵⁵.

In March 1992, two training courses to raise awareness of gender equality issues were organised for 24 departmental women's group representatives from nine SRC departments¹⁵⁶. This was followed up later in the year by a pilot programme of equality training with the Central Training Unit of the Personnel Services Department.¹⁵⁷ In

¹⁵¹ GDC Town Clerk's Office (1993) *Memorandum for Mr Andrew Lyon, Healthy Cities Co-ordinator, From Tom Monaghan, Town Clerk and Chief Executive (07/05/93)*

¹⁵² SRC Advisory group on Women's Issues (1992) *Advisory Group on Women's Issues progress Report January 1992 - Report by the Women's Officer (12/02/92)*

¹⁵³ Strathclyde Regional Council (1992) *Advisory Group on Women's Issues Minutes (12/08/92)*

¹⁵⁴ SRC Advisory Group on Women's Issues (1992) *Women's Unit Progress Report September/October 1992 - Report by the Women's Officer (28/10/92)*

¹⁵⁵ SRC Advisory Group on Women's Issues (1992) *Women's Unit Progress Report November/December 1992 - Report by the Women's Officer (12/92)*

¹⁵⁶ Assessors, Consumer and Trading Standards, Chief Executive's, Architect's, Building and Works, Roads and Internal Transport, Education, Social Work, and Strathclyde Business Development.

¹⁵⁷ SRC Advisory Group on Women's Issues (1992) *Women's Unit Progress Report August/September 1992- Report by the Women's Officer (09/92)*

addition a 'gender equality' seminar was organised for Heads of Departments in November 1993. The aims of this seminar were to:

- *examine the importance of gender equality from a human resources and service delivery perspective*
- *identify the barriers preventing women progressing within organisations*
- *look at possible departmental and corporate strategies to remove such impediments*¹⁵⁸

The trainer's evaluation of the event noted how the participants' responses had been positive, though enthusiasm for different sections varied considerably. She concluded that whilst SRC had some good schemes on paper, their implementation was 'patchy', and that,

*some departments implement only the letter and not the spirit.*¹⁵⁹

She was surprised at the lack of awareness of the views of women, of the barriers they faced, and that many of the gender equality issues raised were completely new to the majority of participants.¹⁶⁰

5.2.5 Responding to organisational policies and consultation documents

Another key activity of the WHWG involved responding to policy consultation documents of the various organisations, for example GGHB Local Health Strategy and GDC City Vision. In general such responses focused on the lack of inclusion of women's health issues, and in some instances were eventually successful in their action. For example, following a response to the Community Care Plan, which had contained no reference to the needs of women or carers, a working group was established by the Joint Planning Forum to look at women's issues¹⁶¹, and the needs of women were included in the final document¹⁶².

The GGHB WHPWG were involved in responding to consultation documents for the inclusion of gender issues in Health Board policies and strategies, for example the Mental

¹⁵⁸Strathclyde Regional Council (1993) *Gender Equality Seminar Trainer's Evaluation - Report by Carol Craig (11/93)*

¹⁵⁹Strathclyde Regional Council (1993) *Gender Equality Seminar Trainer's Evaluation - Report by Carol Craig (11/93)*

¹⁶⁰Strathclyde Regional Council (1993) *Gender Equality Seminar Trainer's Evaluation - Report by Carol Craig (11/93)*

¹⁶¹Women's Health Working Group (1995) *Minutes 07/03/95* (Glasgow: Women's Health Working Group)

¹⁶²Women's Health Working Group (1995) *Minutes 61/06/95* (Glasgow: Women's Health Working Group)

Health Strategy¹⁶³, and the Joint Community Care Plan¹⁶⁴. The WHPWG were not invited to participate in the development of the Board's Sexual Health Strategy as the development group reportedly did not feel it was 'appropriate'¹⁶⁵. The WHPWG sought information on the Board and NHS Trust policies on equal opportunities¹⁶⁶, and for the inclusion of childcare facilities in the planning for the relocation of the Health Board headquarters, although without success¹⁶⁷.

In SRC, the Advisory Group on Women's Issues used a consultation exercise on the Social Strategy review to highlight the central role of the Women's Health Policy. The draft document contained no reference to women's health needs resulting from poverty, their role as carers, mental health problems, violence and complex reproductive systems, and the AGoWI recommended that,

*Women's Health Policy ... be a core part of the Social Strategy, and the health needs of women to be clearly addressed proactively throughout.*¹⁶⁸

No similar action was located within GDC.

5.2.6 Service developments

Of the statutory partner organisations, GGHB was unique in progressing changes to services. The WHPWG successfully lobbied to have the implementation of the WHP included within the GGHB service agreements with the NHS Trusts¹⁶⁹. They were also successful in securing the inclusion of the WHP in the GGHB annual purchasing plans¹⁷⁰. One of the key developments of the Group was lobbying for the expansion of the Ballantay Model Well Woman Clinics to a further nine clinics. The Ballantay model was introduced as a pilot project in the late 1980s as a means of implementing a social model of women's

¹⁶³ GGHB (1993) *Women's Health Policy Working Group Minutes* (11/03/93)

¹⁶⁴ GGHB (1994) *Women's Health Policy Working Group Minutes* (08/12/94)

¹⁶⁵ GGHB (1994) *Women's Health Policy Working Group Minutes* (21/04/94)

¹⁶⁶ GGHB (1994) *Women's Health Policy Working Group Minutes* (18/08/94)

¹⁶⁷ GGHB (1995) *Women's Health Policy Working Group Minutes* (23/05/95)

¹⁶⁸ SRC Advisory Group on Women's Issues (1993) *Social Strategy Draft Consultation Document - Draft Response by the Women's Officer* (24/03/93)

¹⁶⁹ GGHB (1993) *Women's Health Policy Working Group Minutes* (11/03/93)

¹⁷⁰ GGHB (1993) *Women's Health Policy Working Group Minutes* (15/12/93)

health (see Craddock *et al.*, 1990; Craddock and Reid 1993). In addition a breast feeding initiative was established in Easterhouse using lay women as befrienders to encourage breast-feeding in 1994¹⁷¹.

5.2.7 European Links: Women and Health MCAP and the "Glasgow Model"

The WHWG had established links with the WHO European Healthy Cities Project, including involvement in the Women's and Health MCAP (Multi-City Action Plan). In March 1994 Glasgow was approached to take over as the co-ordinating city of this network¹⁷². The Women's Health Working Group organised a MCAP event in June 1994¹⁷³, which was used to harness the support of other member cities for the adoption of the Glasgow Model of Women's Health, based on the Women's Health Policy. In 1995 it was reported that the WHO were to consider adopting the Glasgow Model of Women's Health as the model for Europe at their December meeting¹⁷⁴. This was followed by the agreement at a MCAP meeting in early 1996 to submit an application for EC Ouverture funding using the Glasgow Model for Women's Health as the basis of the proposal. The application for funding was unsuccessful¹⁷⁵, and no further progress on the MCAP was made during the period of analysis. However, in October 1996 it was reported that Glasgow had been invited to put forward an application to the WHO to be considered as a Collaborating Centre for Women's Health, with GGHB acting as the local co-ordinating institution¹⁷⁶. This did take place, with Glasgow being the Collaborating Centre since 1997. In addition the WHO were impressed by the 'Action Pack' produced and requested that it be used as the basis for European guidelines for action on women's health in cities¹⁷⁷.

Developing European links can be seen as an important means of strengthening the position and status of the work of the Women's Health Working Group in Glasgow. In

¹⁷¹ GGHB (1994) *Women's Health Policy Working Group Minutes* (27/01/94)

¹⁷² Women's Health Working Group (1994) *Minutes* 01/03/94 (Glasgow: Women's Health Working Group)

¹⁷³ Women's Health Working Group (1994) *Minutes* 11/01/94 (Glasgow: Women's Health Working Group)

¹⁷⁴ Women's Health Working Group (1995) *Minutes* 07/11/95 (Glasgow: Women's Health Working Group)

¹⁷⁵ Women's Health Working Group (1996) *Minutes* 03/09/96 (Glasgow: Women's Health Working Group)

¹⁷⁶ Women's Health Working Group (1996) *Minutes* 01/10/96 (Glasgow: Women's Health Working Group)

¹⁷⁷ Women's Health Working Group (1996) *Minutes* 05/11/96 (Glasgow: Women's Health Working Group)

addition, in 1997 the GHCP received a Commonwealth Award for Excellence in relation to work on women's health.

5.2.8 Summary

This section has reviewed a range of action identified through documentary analysis and interviews, as examples of how the WHP has been implemented. It is clear that some core changes have taken place, not least in terms of the realisation of a CFWH, the establishment of women's fora within two organisations, and service developments. Much of this action can be seen as developmental, for example raising awareness, and producing reports and information. Some of the work can also be seen as strategic, for example, building alliances within Europe. However, it is clear that such developments have in many cases been far from easy. The interviewees' perceptions of the difficulties encountered will be explored further in Chapter 6. First, the perceived enablers to the implementation of the WHP are explored.

5.3 Enabling implementation

Eight core categories of enablers have been derived from the interview data. Each of these categories were raised by interviewees from all of the partner agencies. These themes were: the development process; organisational support; organisational structures; access to power; agency; strategies and action; concept of health; and context. Each will be discussed in turn.

5.3.1 The Development Process

The majority of Women's Health Working Group interviewees considered the process through which the Policy had been developed to have increased the potential for its implementation. Three aspects in particular were seen as important: its development through a process of consultation with community involvement; its status as a women-led initiative; and its co-ordination by a multi-agency group.

Several interviewees highlighted the importance of the Policy being developed in a consultative way within organisations and with women in the community. In this way the Policy was seen to be an adequate representation of the concerns of women, legitimating the basis of its content, direction and approach.

The fact that there was a consultation exercise meant that the Policy at least had the agreement of women in communities. This is something women were looking for, this is not something which was devised by medical people, by academics, by people who were looking at it from three steps back from reality as it were. (SRC Interviewee 10)

The 'bottom-up' approach to the development of the Policy through years of campaigning for action on women's health from a position outwith the decision-making structures of organisations, in addition to the consultation of the draft Policy itself, was seen by many as being of central significance. Some interviewees commented on the importance of it being a women-led approach, being 'written by women for women'. In this way the Policy was seen to be giving women a 'voice' within the organisations, empowering women and enabling them to shape the agenda. For some, it was perceived to be promoting interest amongst a wider group of women within the organisations.

The end product of this consultation process, the development of the Policy itself, with a series of principles and ideas written down in a document which could be used within organisations was highlighted as being of particular importance. Some interviewees also commented positively on the format, content and basis of the document. It was considered to be simple, clear and concise, rather than going into great detail, which some interviewees felt would be 'off-putting'. Its simplicity was also seen as a benefit in enabling it to be more flexible and open to interpretations by the organisations.

I think it's clear and I think it's simple, which I've always thought was a strength, because I think the simpler policies can be better understood, and the more chance you will have of people implementing them. (SRC Interviewee 3)

The existence of a Policy was essential in order to ensure action, due to the neglect of attention of such issues in the past. Many interviewees considered that such a neglect would continue in the absence of the Women's Health Policy. Other interviewees stressed the importance of its development through multi-agency process which was considered to

have facilitated co-operation between organisations. Several interviewees commented on the tension that existed between the organisations, and the general difficulties that had been experienced whenever organisations and even departments within the same organisation had attempted to work together on a range of issues. In the light of these difficulties some interviewees perceived the development of the Policy and its adoption by the statutory partner agencies an achievement in itself. However, one of the central aims of implementing the Policy was to raise awareness of its relevance to all agencies. For some, the multi-agency development helped promote such an awareness, and a multi-agency ownership of the Policy which had further legitimated the implementation.

I think the multi-agency bit of it has been very important. At a time when health boards and local authorities were daggers drawn the Health Policy was an important channel of communication. You know it was evidence that we were all interested ultimately in the same things. (GGHB Interviewee 5)

A multi-agency approach was seen as being both necessary in order to improve women's health and in providing a significant lever for action:

the leverage it gave in order to get that concentrated focus taken through the development of the Centre for Women's Health because I think one of the most powerful expressions of alliance working between statutory and other agencies is when they actually put their heads together and put money into something. (GGHB, Interviewee 11)

This issue links to the following theme of organisational support.

5.3.2 Organisational support

Several interviewees highlighted the formal adoption of the WHP by the statutory sector organisations as being a key factor in enabling its implementation within these organisations. Whilst this may on the face of it appear obvious, several reasons were highlighted by interviewees as to why gaining such support was so important. Firstly, it should be remembered that several people involved in the development and implementation of the Women's Health Policy had been involved in campaigning on women's health for a number of years. The formal adoption of the WHP in this context represented a recognition of the importance of women's health to organisations. In addition the formal adoption of the Policy was seen as a further step towards a women's

health perspective being included within the formal policies and structures of the statutory organisations. For many, the prior position of being confined to informal contacts and lobbying organisations had been a barrier to promoting action on women's health. As such, the formal adoption of the Policy was seen as a major step forward.

Secondly, the Women's Health Policy was developed to act as a lever, due to the perceived limited ability of the WHWG to influence or promote action within the organisations. For many, the existence of the Policy had achieved this aim, providing the tool they needed to put women's health on the agenda of organisations. Thirdly, the Policy was seen as legitimating or providing a framework for work that was already occurring within the organisations, supporting or defending its continuation.

Fourthly, the ownership of the Policy, as demonstrated by its formal adoption by organisations, was perceived to be of great importance. For many interviewees this represented a commitment by the partner organisations to the implementation of the Policy. A few representatives from particular departments which had been active in the Policy fora felt that departmental support had also been vital to the implementation of the Policy. However, as the following quote suggests, questions remained about exactly how much commitment there was.

It's written down...I think it's important that something is written down and it's made available and it's short and snappy and you can use it. The fact that it doesn't get used is another story...And it was agreed, I think the Policy has to be owned by the people that sign up to it, and so there's a common ownership to it.
(SRC Interviewee 14)

5.3.3 Organisational structures

The establishment, firstly of the Women's Health Working Group and later the organisational women's fora were seen as key enablers to the development of action on women's health in the statutory sector organisations. In relation to the WHWG, the role of the Group as a whole, as a network and an instigator of action, were highlighted.

All WHWG interviewees highlighted the importance of the networking role. Interviewees spoke positively of the supportive nature of the Group, and as a means of sharing

information and ideas. The diversity of organisations and professional backgrounds included within the Group was also seen as a strength, leading to an increasing breadth of understanding for members.

Once you start going to things like the Women's Health Working Group and you meet and you hear about what's going on in other agencies then you start to make links that you wouldn't normally have made and you start to involve people and you start to involve people that you would never have thought of involving. (GGHB Interviewee 2.)

The structure of the Group was considered by some to be non-hierarchical and participatory, enabling open discussion. One interviewee felt that its women-only membership was a particular strength, in terms of the common understanding of the barriers which may exist within organisations and recognising the limitations for action. In addition she felt the women-only membership led to a more constructive approach:

I also feel that because we were all women we were able to have differences of opinion without getting into the scenario of 'I don't agree with that so I've got to think of something to counter it'. There was maybe more of an acceptance that if we were doing something wrong we were able to admit that. (SRC Interviewee 10)

Some interviewees highlighted the importance of women working at a number of different levels within those organisations being included within the membership. For others, the senior-level representation on the Working Group was important in enabling them to influence decision-making, whilst others recognised this may have led to the reluctance of others, particularly community groups to become involved.

The fact that there are sort of fairly high level of representatives on it, although that maybe puts off some local women getting involved, or workers that maybe have more experience of working on the ground, I think in order to impact on some of the areas you actually need that kind of level of representation. (GDC Interviewee 12)

Some interviewees emphasised the creativity of the Working Group in developing ideas and making links between organisations in terms of areas of interest and potential action. The long history of involvement of some members of the WHWG from different professions and organisations had contributed to the development of common ideas and understandings,

I think it's speaking with a common voice. Different people coming at a problem with a common voice is a huge strength because otherwise it weighs you down. (GGHB Interviewee 8)

In a similar way to the WHWG, the development of the organisational women's fora were seen as significant enablers in providing arenas for women's issues to be discussed within the organisation and the development of a network of women. In the case of GGHB and GDC the adoption of the Women's Health Policy by these organisations had been instrumental in the establishment of women's structures. Several GGHB interviewees stated that their interest, commitment and enthusiasm for work on women's health had increased as a result of being members of the WHPWG. As one interviewee noted being part of such a network offers the benefits of support and an opportunity to focus,

You can get really bogged down at work with patient management, bed numbers, it's actually very good to go out and meet everybody else whose involved in these areas to kind of remind you of what the essential objectives are and bring you back to the same basis, (GGHB Interviewee 4)

In the case of GDC, the adoption of the Policy was credited by several interviewees with the ultimate realisation of a Women's Committee. The SRC women's structures had been established previously, but as several interviewees commented, the adoption of the Women's Health Policy had provided a clearer focus for the development of women's issues within the organisation. Whilst the establishment of a Women's Committee within GDC was seen as beneficial by some GDC interviewees in terms of increased power and 'political clout' within the organisation, most SRC interviewees indicated that the establishment of working groups and advisory groups had been a preferred approach to gaining support from elected members within the organisation.

Of the 103 members 12 or 13 of us were women and not all of them were supportive of women's policies. I think if we had tried to set up a separate committee we would have alienated more people. I think by doing it the way we did we really put a sounder base on it. We could maybe have achieved more but I think we would have disappeared quickly because people would have seen us as aggressive. (SRC Interviewee 10)

Some interviewees felt their organisational women's fora were better placed than the multi-agency WHWG to facilitate or develop action in relation to health by being located within

the decision-making structure of the organisations and better able to lobby key people. In addition, the smaller and more focused single agency groups were felt by some interviewees to have a 'better grasp' of the Policy in terms of being able to identify ways to make it work within their organisation. As one interviewee noted,

it was things that were more common to Parks and Recreation if you like and I'm sure we actually tried to break down the Policy in areas that could be addressed within the Council... and tried to get a sense of ownership (GDC Interviewee 5)

As with the WHWG, the presence of senior members and strong leadership with access to power were seen as important in relation to each of the organisational women's fora, as will be discussed in the next section.

5.3.4 Access to power

A key issue emerging from the interviews, and central to several categories, has been the importance of access to power, specifically senior and political support within the statutory partner organisations. For interviewees from each of the partner organisations, but predominantly Glasgow District Council and Strathclyde Regional Council, the establishment and continuation of support at the highest levels, but crucially of councillors were seen as vital to the implementation of the Policy. Without it nothing could happen.

Once it's politically owned then it becomes much easier because it then has to be owned by the officers... You see the political ownership in government is extremely important and that's why some political women in the Council is obviously going to be key to the future of the Women's Health Policy. (SRC Interviewee 3)

Within the Health Board, as a non-elected agency, this was characterised as 'formal support' through the adoption of the Policy. As highlighted in Chapter 4, the WHWG had sought senior and strategic representation, with the involvement of the Lord Provost of GDC as the Chair of the group being seen as a key breakthrough. Formal or senior/political support was also seen by many interviewees as being central to the development of the intra-organisational fora within the Glasgow District Council and Greater Glasgow Health Board. Senior representation on these fora was seen as crucial to the implementation of the Policy.

In the Board they have a steering group (WHPWG), they have it headed up by a non-executive director and the people they have around the table are at a level in the organisation to be able to make decisions. (GGHB, Interviewee 1)

Having a WHWG Chair who had access to senior levels of organisations and was a member of the GHCP Planning Group was identified by several interviewees as increasing the potential for policy implementation. Similarly Greater Glasgow Health Board interviewees highlighted the importance of having a co-ordinator with a remit to oversee the implementation of the Policy and a Women's Health Team as being hugely influential on the development of work within the Board and the Trusts.

I think the fact that the Board have someone working on it has helped a great deal. I think dedicated officer time has to be involved in the implementation of the Policy. (GGHB Interviewee 2)

The linking of the Women's Health Working Group with the Healthy Cities Project was particularly highlighted by SRC representatives who considered the multi-agency senior involvement to have facilitated the adoption of the Policy and the establishment of the Centre for Women's Health.

The Healthy Cities Representative at the time was Vice-Convener and then Convener... he was extremely helpful because the idea of a women's health centre had been going for years but nothing had ever come to fruition, and I don't think it would have happened without his influence and his support, to get the money out of Strathclyde, to link in with the District Council and the Health Board. (SRC Interviewee 6)

Similarly the multi-agency commitment itself was again highlighted by Strathclyde Regional Council and Greater Glasgow Health Board representatives as playing a significant role in the implementation of the Policy.

Oh, multi-agency commitment, the fact that none of the agencies involved have stood up and said that this is a load of rubbish and we're not supporting it. I think if you've got multi-agency commitment then you can make things happen (GGHB Interviewee 5)

Finally, a number of interviewees commented that the increase in the number of women in senior positions within their organisations had a positive impact on the reception of issues within their organisation.

Women in senior posts can influence the organisational culture to make life easier for women, because I think most of them at some time appreciate the additional demands that women have to face in their working life if they are going to have a family and choose to work. (GGHB, Interviewee 4)

5.3.5 Agency

In addition to power, organisational structures and support, the agency of individuals was seen as possibly the most crucial enabler to the implementation process across each of the partner organisations. Glasgow Healthy City Project and Women's Health Working Group interviewees pointed to the key role played by several Women's Health Working Group representatives, perhaps first and foremost the Chair of the Group and the Health Board's Women's Health Policy Co-ordinator.

I think undoubtedly first of all there is a champion for it who was tenacious in ensuring that the Policy achieved a level of adoption and understanding within the Board that was at the level of the Board itself. (GGHB, Interviewee 11)

It was the continuing commitment and enthusiasm of these key women who were involved in the development of the Policy which was seen as the determining factor in the development of formal support, the adoption of the Policy and the development of structures within the organisations.

I think the existence of a group of dedicated and competent women who want to see it through has helped, and having political support in the right places at the right times has helped it as well. (GDC, Interviewee 2)

Several interviewees pointed to the informal lobbying outwith formal structures as a significant enabler to the implementation of the Policy.

It actually needed somebody from the Working Group to raise that where the decisions were being made. It wasn't coming down from the Women's Health Policy, it was literally somebody from the Working Group had to pursue it before you felt there was any impact. (SRC Interviewee 14)

The support from key politicians and senior officers was also highlighted. Some of these were involved directly with the Women's Health Working Group, some with the GHCP and others held key positions within their organisations. The support of senior political individuals was significant both structurally, due to the key positions and power held by

these individuals within their organisations, but also as a means of agency due to their individual efforts.

We had a number of key women elected members... who were prepared to agitate and prepared to push the cause even though it made them unpopular, and also to work away at forming alliances (SRC Interviewee 3)

I think that it's just the very high commitment of people over a considerable number of years who know how to get round the system and have managed to, despite very little assistance I would say, make the Women's Health Policy at least adopted in principal if not in practice by the agencies. (SRC Interviewee 14)

Several interviewees commented on the importance of individual personalities in the implementation process.

I think a lot of it rested on individuals and individual personalities in whatever has been achieved. I think it has been through an awful lot of hard work and determination, applying consistent pressure to keep it up there, to keep it in the spotlight. (GGHB Interviewee 8)

5.3.6 Strategies and action

Some interviewees commented on the importance of the strategies employed in seeking to implement the Policy. Interviewees from all organisations considered implementation to have been opportunistic, seeking relevant vehicles to pursue the implementation, such as through available funding or other resources. A 'softly, softly' approach was highlighted by Glasgow District Council and Strathclyde Regional Council interviewees who saw the key to action in being diplomatic, realistic and seeking incremental rather than wholesale change.

I suppose being non-confrontational... And by being very pleasant about it you can take people on board with you. I sometimes think that if you're confrontational you turn people off right at the beginning. (SRC Interviewee 13)

Related to this some interviewees highlighted the approach taken in the Policy, of seeking change within organisations to be more realistic, in not calling for additional resources but for a change in approach.

It wasn't asking for huge resources to be added to, whether it was local authorities or health boards or the voluntary sector, it was something which could be incorporated into the ordinary work of either a local authority, a health board or a

voluntary organisation if you just perhaps changed their working practice. (SRC Interviewee 10)

A number of the interviewees commented on the action of the WHWG in developing the Policy and raising the profile of women's health as being a significant enablers. As one interviewee noted,

It has been quite effective in raising awareness of the issue. I mean it has created a lot of antagonism because this issue does create a lot of antagonism. It has been dogged, it has kept going, it has managed to produce a document which I think has provided some leverage within the organisations to take the issue forward. (GGHB Interviewee 4)

Harnessing the support of other organisations were seen as strategies by Greater Glasgow Health Board and Strathclyde Regional Council representatives, in particular the multi-agency approach of the Policy. To some extent playing organisations off against each other was seen as instrumental in having the Policy adopted by the partner agencies and securing funding for the Centre for Women's Health.

The Leader of the Council was supportive. I think in a way he didn't have much of an option. I think the way it was put was 'Well Glasgow's doing it, the Health Board's doing it, Strathclyde has to do it'. (SRC Interviewee 10)

The establishment of the Centre for Women's Health was seen as enabling the implementation of the Policy by some interviewees, in providing a physical focus and profile, and later a model of good practice. For others the significance lay in the process of acquiring funding, which had begun with a bid for European money and led to the commitment of organisations.

European funding can always act as an incredible carrot because they (the organisations) think they are going to get some money and when we put that bid in and didn't get any money it was a Trojan Horse. I mean you can't apply for European money without taking the idea right to the top of an organisation, and whilst you are at the top of an organisation you get other stuff out as well... and that's why it was funded locally. (GDC Interviewee 2)

Another aspect of this use of other organisations was highlighted by Greater Glasgow Health Board representatives who commented on the credentials attached to it being a Healthy Cities Project linked to the World Health Organisation. In particular the recognition of the Policy at the European level with the adoption of the Glasgow Model of

Women's Health by the WHO was considered to have raised the profile of the Policy within Glasgow.

The fact that now it's recognised at a European level. I don't think it makes a sod of difference to local women, but it does to the major agencies involved who you are asking to implement the Policy. (GGHB Interviewee 10)

A few interviewees commented that they considered the issue focus of much of the work, particularly on domestic violence, had enabled the implementation as issues were easier to digest than broad concepts. Others commented that the publicity generated by the launch and subsequent events had aided the implementation through raising awareness of the Policy. In one case a Glasgow District Council representative who considered implementation to be low within her organisation commented that the Women's Health Policy event held shortly before Glasgow District Council was disbanded had led to a developing awareness within departments.

I mean it wasn't until they got into this mode of thinking about it in the broad sense of women's health that they started to realise that they did have a part to play. (GDC, Interviewee 12)

Within the GGHB the establishment Women's Health Policy Co-ordinator position was seen as particularly important to the progression of work within the organisation.

She holds everyone together and knows exactly where she wants to go and has good ideas. She understands the various strengths and weaknesses that people bring in their particular field... you've got people in positions of power who can influence Health Board policy, because if you don't have that it's hopeless. (GGHB Interviewee 4)

Other issues highlighted were the development of research and reports which it was felt had provided support for the Policy and increased awareness. For some interviewees the research undertaken had 'grounded' the Policy, and provided evidence to support the need for the Policy.

5.3.7 Concept of health

The broad definition of health encompassed by the Policy was also seen as central to its acceptance by WHWG representatives from each of the partner organisations. Strathclyde

Regional Council representatives commented on how the broad definition of health contained within the Policy was valuable for integrating the work within different sections of their organisations, and with other organisations. For Health Board representatives this broad definition was important for developing a shared responsibility for health with the partner organisations, and also for enabling the development of work on a broader range of issues, such as domestic violence, within their organisation:

Five years ago if you talked about domestic violence, it was nothing to do with us. Now I think it is, so the issues are being raised. (GGHB Interviewee 4)

A few Glasgow District Council representatives commented in particular on the significance of the Policy being a 'women's health' rather than a 'women's issues' document as enabling its acceptance within the organisation, suggesting a greater palatability of health rather than gender issues.

It was easier having a women's health policy because it was easier than having a women's policy, not as threatening or alarming as looking at women in general. (GDC Interviewee 13)

5.3.8 Context

Aside from the structures, the agency and the strategies associated with the implementation of the Policy, some interviewees perceived several contextual issues which they felt had contributed to the acceptance and implementation of the Policy.

Strathclyde Regional Council interviewees raised the importance of having more women in senior positions, creating what was felt to be a more supportive environment. In addition, departmental restructuring, and the presence of existing policies with a common understanding, such as the Social Strategy, were also highlighted.

I think Strathclyde's other policies helped, the anti-poverty strategies, the community development approach, all these things existed in Strathclyde. The progressive policy in Strathclyde helped because it wasn't new to people. (SRC Interviewee 3)

Some interviewees felt there was a growing awareness, receptiveness and acceptance of issues relating to women's health, gender equality and the complex inter-relationships

creating health within their organisations, that the 'time was right' for such a policy. Some interviewees suggested that validation for the Policy had arisen through the development of similar action and policy initiatives on a national and international scale. These developments have largely occurred since the period of analysis in this research, but have been raised by interviewees as further supporting the legitimacy and approach of the Policy. In the UK such developments have included the commitment to women's issues within the present Government and the establishment of Ministers for Women in England, Scotland and Wales. In addition partnerships and collaborative working for health have been emphasised in the development of Health Action Zones in England, and in the White Paper on the NHS in Scotland "Designed to Care" (1997), and the Green Paper "Working Together for a Healthier Scotland" (1998). At the European level there has been the commitment to mainstreaming equality within EU policies and programmes. Similarly the WHO European Office has indicated its support for the mainstreaming of women's health initiatives (WHO 1998).

Despite the majority of interviewees being able to comment on their perceived enablers to the implementation of the Policy, there was a significant minority who for varying reasons felt unable to make suggestions. Some felt unsure or could not remember. Some had never thought about it, had never worked with it or did not feel familiar enough with the Policy to comment. What is surprising is that the majority of those who felt unable to comment were involved in the organisational fora charged with overseeing the Policy. On a more negative note, one interviewee commented that "*it needs to happen first*".

5.4 A separate women's policy?

One area of interest in this research concerned the interviewees' perceptions of the Policy, in particular the need for a separate policy on women's health. This question was asked in order that support for the WHP was not presumed or taken for granted. In response to the question "Is there a need for a separate Women's Health Policy?" the response of the majority of interviewees was positive. Three distinctions can be made between the responses, which were in some cases discrete, in others overlapping. These are:

- **gender difference**, drawing on the unique experiences and needs of women in relation to men;
- **gender inequality**, which focuses more in the social and structural factors which affect women negatively, and thirdly
- **strategy**, which draws on both the above distinctions but focuses more on how best to operate and implement the Policy within the organisations.

Firstly, some interviewees considered there to be a need for a separate women's health policy due to differences between men and women in terms of health needs and experiences, because of women's role as carers in the family and the ability to shape the health of others.

I think women are very different from men, there are different kinds of problems that affect women, but there are also different kinds of solutions that women can apply. They do have more influence in families. (SRC Interviewee 7)

Notions of women's gender role ranged from those which celebrated the important part women play in the health of families and communities, to those who argued that socially constructed gender roles reinforce gender inequality.

Society constructs this particular role that they're in and by doing that they actually aggravate problems rather than alleviate them. I think it's about having some recognition that that's what happens in society, this is how women's health is affected and this is how we should start and try to address that and address the imbalance. (SRC Interviewee 2)

The reasons given in relation to gender inequality range from concerns about male dominated professions and the need for more women in decision-making, to the need to develop a broader understanding of what 'women's health' is by including more areas than those traditionally associated with 'women's health', such as reproductive health. The existence of inequalities between women is also raised:

the medical profession is run by men... I think a lot of things are not available to all women, women living out in the estates and that, they're not as likely to make use of what's available under the NHS, and male doctors and particularly psychiatric services tend to fob people off with pills instead of trying to get down to the root causes...there still is a need for a lot more information about women, and more women in decision-making at the top end of the health profession. (SRC Interviewee 6)

As a means of highlighting gender inequality, some thought the Policy was particularly important due to its holistic nature, broadening traditional concepts of health and making the links between the various influences:

I don't see any other way... Women's health, because people's understanding about women's health, because it's so broad that it's actually a policy about good staff relations, it's a policy about equality, it's a policy about poverty and so in a way it's a more a principle based on women's health... I think you need a women's health policy, you need to grasp the big picture. You could call it a women's policy, it's closer to a women's policy than a women's health policy, but the trouble with a women's policy, again might be very difficult to do. So it gives it at least some kind of focus, say that it's a policy that looks at women and the impact on their health. (SRC Interviewee 14)

The above quotation links in with the third distinction of 'strategy', that strategically there is a need for a women's health policy. The reasons given within this category referred mainly to it being a necessary tool, a focus so that the issue does not fall off the agenda.

Well it's like all these things you know. There's pro's and con's both ways. Probably given the blindness that there's been in terms of gender issues we do have to go through the stage of focusing particularly on women... while that's not happening there's a danger that any policy set up would completely ignore the very particular issues of those groups... You go through what you hope is an interim stage of positive action and until you do that you simply don't get the issues of particular groups highlighted. (SRC Interviewee 17)

While recognising the disagreement over whether a separate policy was the right approach to take, some interviewees also suggested that without the support of a policy action on the issue would at best be tokenistic. For example:

I'm aware of some of the arguments of why there shouldn't be a separate policy and that women's issues should be built into other policies and I agree with that, but the difficulty with taking that route on it's own without any capacity to make sure that happens is that it doesn't happen. It's another aspect of policy implementation, you know what politician in, usually his, right mind is going to say we are not going to support the emancipation of women, we are not going to support equal access for women, we are not going to support action on women's poverty. No politician's going to say that. But trying to get them to implement something is a different kettle of fish... But the reality of getting something done without that kind of direct influence of a policy would be more difficult and less effective. (GDC Interviewee 2)

Whilst the existence of a separate policy was seen as important to get the issues on the agenda, some interviewees argued that this alone was not enough, that the policy had to

inform mainstream policies within the organisations in order to be effective. If not, there was a risk of marginalisation. For example:

Yes I think there is a need for a separate policy, but I think it's important to make sure that that doesn't mean that the main policies ignore women, as I think can always be the tendency. (GDC Interviewee 9)

Within this category there is the strong implication that there is both the existence of gender inequality and the exclusion of gender issues within organisations, and also strong sense of opposition to the promotion of gender issues. There was also the sense that having a separate policy was a necessary stage prior to acceptance of such issues within the mainstream and that it is necessary that such policies inform the mainstream of organisations rather than remaining as separate entity.

Because I think that nothing would happen unless you made an issue of these issues... I mean a lot of people say, well you know women's issues shouldn't be treated separately, they should be integrated into everything that happens and I mean ideally I would like that to be so too. But it doesn't happen unless you do actually try and act on them because in our society, I mean if you take the analysis of society that I do that women still don't have equality, don't have equal sets of rights then you are not going to get change by not talking about it and struggling for it. (GGHB Interviewee 9)

Other, mainly senior male, interviewees were less committal, arguing that if there was a need then there should be a separate policy. Such responses may have arisen from the lack of direct involvement in the Policy, but may also be an indicator of a lack of interest. Some women were similarly less enthused, suggesting that if there is a women's health policy then there should also be a men's health policy

Yes but it has to complement that of men because I think there are actually bigger issues around men's health... I think we should be working much harder on men's health, I think there are an awful lot of issues that men just don't face up to. (GDC Interviewee 15)

Arguments by interviewees of the need to focus on men's health predominantly presented the case in terms of a biomedical concept of men's ill-health, and represented a misunderstanding of the aims of the Women's Health Policy.

Several interviewees disliked of the strategy of having separate policies, stating a preference for generic policies which recognised different needs and experiences, but acknowledged that in this context a separate policy had been beneficial or necessary.

I'm absolutely clear there's specific action that needs to be taken around women's health, but I believe that although women have a different experience of the world which therefore affects their health which is why you have to be very gender focused, I believe in gender sensitive planning but I'm not absolutely sure that I believe in gender specific policies other than around employment or opportunities or whatever.... But maybe it had to be because it wasn't possible to integrate it. (SRC Interviewee 1)

This interviewee stressed the importance of gender inclusion but considered that strategically separate policies would diminish the possibility of implementation due to sexist opposition within organisations. This feeling was echoed by other interviewees,

I think we need a policy promoting health in its widest sense... Whether it needs to be a separate women's health policy, which puts quite a lot of people off, is another matter. I support the Policy wholeheartedly, but I think there's a perception out there of it being not really relevant. (GGHB Interviewee 3)

Others described how their strategy for implementation within their organisation had been changed in the face of this opposition to take a generic health policy approach. For example:

I am having difficulty with it. I ... felt it was best to integrate it into staff health policy as opposed to a women's health policy, and we were working towards a women's health fair when we became very aware that a number of men were aggrieved so we decided to turn it into a staff health policy, and things like maternity leave, we're considering paternity leave here. And things like promoting lifestyle advice for women, we think it's equally important to promote it for men. (GGHB Trust Interviewee 1)

Thus, many interviewees highlighted the need for a separate women's health policy as a means of promoting action and getting women's health on the agenda of organisations. Others, whilst recognising the strategic need due to the lack of attention to the issues, disliked the approach. For some this stemmed from the perceived negative impact on implementation by having the policy labelled as 'women's', whilst for others there was a dislike of women's health being presented as a 'special case', arguing that men's health should be similarly prioritised. These issues indicate a preference for generic approaches

through mainstreaming and a degree of resistance to positive action. This issue will be explored further in the following chapter.

5.5 Perceived enablers of multi-agency working

Throughout the previous sections multi-agency working has been invoked as a key strength of the WHP and its development, and an enabler to its implementation. Within this section, the view of the interviewees as to the enablers and benefits of multi-agency working are explored. The issues emerging have been categorised into four groups: necessity; organisational support; agency; and strategy developed. It should be noted that discussion of multi-agency working in this section refers to multi-agency working in general as opposed to specifically in the context of the WHP.

5.5.1 Necessity

A significant push factor highlighted as an enabler to multi-agency working was the *necessity* to do so. Various reasons were given to this, including the increasingly limited resources available to statutory organisations and the lack of ability to solve the problems on their own. One interviewee commented in relation to an urban regeneration project in Glasgow that previous failures of developments by organisations in that area through the absence of a co-ordinated approach necessitated a multi-agency strategy to 'get it right'.

We have had the Gorbals which was a failure and we had the re-vision of the Gorbals which was a failure and what I like about the Crown Street project is the fact that everybody says, 'look we've failed twice, we really can't afford to fail a third time, so let's think about what we want here, let's go through a proper feasibility, let's have a masterplan' (GDC Interviewee 17)

5.5.2 Organisational Support

The availability of resources was also highlighted as an enabler to the process, either as the result of bidding for new resources or through the capacity to combine resources. Some interviewees commented that the issue on the table had to be seen as important to the organisations in order to prompt them to work together. This is facilitated by the existence of senior committed and strategic individuals. One interviewee highlighted these issues in relation to the senior level representation on the Drugs Action Team.

Now these are people who make policy decisions and it is because they are there and able to say, 'this is important enough for me to give commitment to it', and they do that. (SRC Interviewee 4)

Other enablers highlighted included the development of understanding of the organisations involved - their opportunities and constraints, and the building of relationships between organisations. Some interviewees commented that this 'relationship building' was enhanced by the clarification of the roles to be played by the participant organisations within the process. Other interviewees highlighted the need for organisations to be flexible, open and willing to negotiate.

Multi-agency working requires honest sharing of information, willingness to negotiate and make changes, willingness to accept parts of somebody else's agenda. (GDC Interviewee 7)

5.5.3 Agency

Alongside the presence of senior strategic individuals being important for multi-agency working, several interviewees stressed other issues relating to the qualities of the individuals involved. This was variously presented as the need to have the 'right people' involved, key individuals with an interest and a commitment to the pursuit of the work. Several interviewees commented on the importance of personalities.

A lot of it is personalities, a lot of it is the people sitting around the table seeing that they have a common agenda and a common aim. The kind of commitment. I think getting the right people around the table is important. (GGHB Interviewee 11)

Whilst the majority of interviewees' definition of the 'right people' referred to the status they held within their organisation in terms of their power, other issues raised as important enablers were their enthusiasm, comprehension and determination. A further issue highlighted by several interviewees was the importance of developing trust.

Trust I think is the key to it too. If you realise the other guy isn't out to, that you have a common agenda and that it's being followed honestly, that's the key to it. (GGHB Interviewee 5)

Good leadership was also highlighted as an enabler to multi-agency working by some interviewees, both in terms of being able to keep to the agenda, ensuring that action takes place, and that the process is inclusive and supportive to the individuals involved.

5.5.4 Strategy developed

Several interviewees highlighted strategic methods of facilitating the process of multi-agency working. The issue most frequently mentioned was the need to establish a common agenda and a clear set of goals. For many of these interviewees this issue was linked closely to the availability of resources.

I think where there's a clear statement of what is trying to be achieved, where there is the possibility of additional resources to achieve that, especially where resources can be converted in some way to addressing objectives that the organisations might have. (GDC Interviewee 2)

Some interviewees highlighted the importance of personal contact, of meeting people face to face to discuss issues, aiding the development of mutual understanding and rapport.

I think the honest sharing of information and common goals being set... there certainly usually is the pooling of resources because money's tight now, but all of that brings benefits to both the workers who have a closer relationship and a rapport. They know what one another can offer. (SRC Interviewee 9)

Along with the development of a common agenda and clear goals, interviewees also highlighted as enablers the development of a clear plan of action and a set of priority issues. In addition some interviewees commented that a number of achievable practical examples were important motivations in the process of working together.

I think having one or two quick deliverables, if you like, so that people can really see that they've done something and they're not just sitting there talking. (GGHB Interviewee 1)

One Trust interviewee also thought that having a practical, workable example to sell to other organisations acted as an enabler to multi-agency working. The establishment of achievable deadlines to ensure that work progresses was also seen as an enabler to multi-agency working.

5.5.5 Summary

In summary, significant enablers to multi-agency working were perceived by the interviewees to be the necessity for organisations to work together in order to resolve complex problems, and the existence of financial incentives and organisational commitment. In addition, the agency of the individuals has been highlighted, such as the importance of having the 'right people'. Finally, the strategies developed, and having a common agenda, agreed priorities and identifiable outcomes were seen as important enablers to the process. These reflect the suggestion of Hudson (1987) of the need for 'domain consensus', and Webb (1981) of the importance of 'reticulists'.

5.6 Discussion

This chapter has presented an overview of action on women's health that has occurred in Glasgow following the launch and adoption of the WHP by the three statutory partner agencies in the city. It has also explored interviewees' perceptions of the factors and circumstances that have facilitated such action taking place. This final section draws together some of the key issues emerging from the analysis.

As noted in Chapter 4, the reason behind the development of the WHP concerned the limited ability of the WHWG to influence action within the partner organisations. Within this chapter it has been highlighted that the majority of action taking place in relation to the WHP within each of the organisations was largely instigated by the various fora rather than the departments, and was largely dependent on a few key individuals. This process was also largely reactive, with the fora seeking the inclusion of women's health issues within policy documents and strategies rather than the fora being approached for input at the developmental stage. A significant amount of the work also took place outwith the formal structures, and depended on informal lobbying. However, members of the groups can also be seen to be operating proactively, in seeking to identify opportunities and raising awareness.

A number of similarities and differences can be seen in relation to the range of action developed within the various fora. Within the WHWG, activity centred on raising

awareness, developing information and materials, and crafting strategies for the inclusion and implementation of the WHP. In addition, the WHWG continued to seek means to monitor the implementation of the Policy within statutory organisations, which ultimately led to the production of an implementation pack offering guidance, and a redrafting and re-launch of the Policy in 1996. Much of the work of this Group was performed within sub-groups and relied on the dedication and commitment of women often working in their own time.

Of the partner agencies, the GGHB WHPWG appears to have been most productive in developing work in areas relating to the Policy objectives. Decisions on the priority areas for action were established almost immediately and defined centrally by the WHPWG. Members of this group were responsible for: producing a significant amount of research and information; the expansion of model well-woman services; and attempts to secure the implementation of the Policy within the NHS Trusts. This work was undoubtedly facilitated by the existence of key individuals for whom women's health was an explicit part of their job remit. Most notable here was the establishment of the WHP Co-ordinator post to oversee the implementation of the Policy within the GGHB. In addition the work was facilitated by the existence of the Women's Health Team and the availability of research funds. The work was both opportunistic and strategic, resulting from an understanding of the workings of the organisations and identifying means of ensuring the legitimacy of the work, for example through the contracting process with the NHS Trust. Senior representation at Board level, initially through the chair of the Group being a non-executive Board member, and the broader support for the work relating to the Policy at a senior level in the Board were also vital to the progress made. In addition, not only did the Group itself link into the decision-making structure, but had key senior officers at the table who were capable creating action. However, a weak link remained in developing action within the Trusts, and Trust representatives were generally less positive about their role and ability to implement the Policy. This limitation was recognised and the WHPWG made a number of efforts to improve action within the Trusts, for example, initiating pilot projects and changing the organisation of meetings to include Trust visits. Stronger links existed between this Group and the GHCP WHWG, with updates on the activity of the multi-agency group being a standing item on the agenda of meetings.

Within the GDC fora, key activities undertaken centred on awareness raising and the production of information. Beyond this, the GDC fora were less successful in developing action relating to the policy objectives. The primary method of seeking action on the issues identified by the WGWHP was asking departments to prepare reports or supply information. This invariably involved a sequence of reports or presentations by representatives from departments, but it is unclear whether as a result of the discussions any change in policy took place. The issues remained largely the same throughout the lifetime of the Group, and little or no outcomes were indicated within the documents. It appears as if the WGWHP lost momentum, possibly due to its concentration on employee issues and the lack of progress made. After the initial examination of the Policy document there appears to have been little reference back to the Policy; rather the agenda of the WGWHP became internally driven and perpetuated.

It is clear that difficulties were encountered in attempts to implement the Policy within GDC. As highlighted in Chapter 4, the establishment of the Women's Committee had not been universally supported, and the lack of senior support within the organisation was also apparent in the failure to establish senior management awareness training sessions, and in the note of caution expressed by the Town Clerk about trying to move things along too fast. In addition there was a perceived lack of centrality to health within the organisation, which is perhaps reflected in the narrow conceptualisation of employee health care and personnel issues. However, despite the range of obstacles identified, the structures that were established within the organisation can be seen as significant achievements in themselves, enabling some level of debate to take place within the organisation concerning women's health.

Within SRC, the AGoWI had existed prior to the launch of the WHP, and as such adoption of the WHP was seen by many interviewees as part of ongoing work. As such, whilst there was little evidence of action in relation to the WHP located within the documentary analysis, several interviewees commented that the Policy provided an important focus and support to existing work.

In contrast to GGHB, both GDC and SRC embarked on somewhat lengthy consultation processes on the Policy with their departments. Such an approach was necessitated by the size, functional differentiation, and public accountability of these organisations. In addition there was a need to build alliances with departments in order to develop action. However, the consultation process led to delays in the identification of action, and a narrow interpretation by departments of 'women's health' with issues identified primarily relating to personnel and health care issues. Such approaches to women's health within the organisations, demonstrating a visible gap between an intellectual understanding of the broad determinants of health and the perceived relevance of these to the day-to-day practice of organisations. In the case of SRC, such a limited identification of issues may in part have stemmed from the prior conduct of departmental consultations and action plans on 'women's equality' producing a restricted definition of 'health' within this broader context of 'equality issues' in general. In addition, the impact of local government reorganisation on the implementation of the WHP by GDC and SRC should not be underestimated. The knowledge that both organisations were to be disbanded allowed little time for forward planning and the development of services.

Whilst the majority of the interviewees identified outcomes which could be related to differing degrees to the WHP, interviewees were less able to comment on the extent to which the Policy was being implemented. There appears to be a general lack of awareness as to what action took place outside the core members of the fora. In addition several interviewees highlighted the issue of 'relevance', which related to the interpretation of women's health within the organisations and the lack of importance attached to women's issues within the organisations discussed earlier, may be seen to limit the potential for implementation of the WHP within the statutory partner organisations.

It is clear, with the exception of the activities within GGHB and the WHWG, that much of the work developed in relation to the Policy was very much at an early and developmental stage. What has also emerged from the analysis, with the exception of the Centre for Women's Health, is the limited amount of actual joint work between the organisations. Once the policy had been adopted by each of the organisations and organisational women's fora established, each of these fora sought to establish and agree their own priorities and

programme of activities. For some interviewees, intra-organisational fora were seen as having greater potential to develop action than multi-agency ones as they operate within the decision-making structure of the organisation.

However, it is clear from the interviews with representatives of the WHWG the importance of this Group in particular as a valuable network and source of support for women. Interviewees spoke of the importance of having a voice, being able to contribute to discussions and of the added value it often had for their work. Also evident within the accounts of these representatives is a clear sense of the marginalisation of women's issues within male dominated organisations, and of the importance of the WHP, the WHWG and the organisational women's fora as a route to change. The women wanted to see change through working with the system, seeking access to the decision-making structures within the partner organisations. Thus it may be argued that a broadly liberal view of bureaucracy was held by the majority of the WHWG, viewing the structures of organisations as neutral, and the potential for change arising from the presence of more women in senior and decision-making positions (Rees, 1999). The analysis of the implementation process within this chapter demonstrates that the approach taken by those seeking to implement the Women's Health Policy within the organisations focused on incremental change as a strategic decision in the light of an awareness of the resistance to the promotion of women's/equality issues within the organisations. This is reflected in the perceptions of some interviewees that 'women's health' was seen as more palatable than 'women's issues', and supports the findings of Cockburn (1991) of the tendency of the 'short agenda' to be accepted, but not the 'longer agenda' of transformative change.

Whilst the WHWG and organisational women's fora were viewed positively by most of the representatives interviewed, the agency, interest and commitment of key individuals was perhaps of greater significance in the development, adoption and implementation of the WHP. This reflects the views of Friend *et al.* (1974) and Webb (1991) who stress the importance of 'reticulists' to multi-agency working, individuals skilled in bridging interests, professions and organisations by working formally and informally. In addition, other identified enablers such as organisational support, access to power, the development process and opportunistic and strategic approach to action, broadly reflect those facilitators

to the implementation of gender inclusion policies identified within the literature (Cockburn, 1991; Halford, 1992; Itzin, 1995b; Thobani, 1995). Also, whilst a number of enablers to the implementation process were raised by interviewees it is evident that these 'enablers' only applied to supporting and legitimating the activities of those women already committed to developing the Women's Health Policy within their organisations. The action developed in relation to the Policy has been characterised as opportunistic and relying on the informal lobbying by key individuals rather than being achieved within the mainstream decision-making or departmental structures of the organisations. This reflects the findings of Itzin (1995b) of the importance of 'crafting strategy' in seeking the implementation of gender policies.

The interviewees' discussions of the reasons for having a separate women's health policy also reflected the debate within the literature between gender difference and gender inequality. However, it is clear that for many of the people interviewed whilst the need to have a separate women's policy was overwhelmingly supported, for many the preferred strategy would have been one of mainstreaming rather than separatist or positive action approaches.

The inability of many interviewees to comment in detail about the Policy or the implementation process raise a number of issues regarding the level of implementation of the Policy within the statutory partner organisations. Significantly many of those who felt unable to comment were department representatives to the organisational fora, indicating a potential barrier to the implementation of the Policy. These issues will be discussed further in Chapter 6.

Finally, multi-agency working has emerged within this analysis as a key enabler to the development and adoption of the WHP. Many of the women involved in the WHWG and the development of the WHP identified the multi-agency approach of women with similar concerns across organisations as a source of strength, support and legitimation. As such, it is clear that members recognised the 'collaborative advantage' (Huxham, 1996) to be gained from working together. Whilst the operation of the WHWG became more formalised over the years, it remained a largely voluntary arrangement, rather than being

directed by legislation or funding incentives (Hudson 1987). In comparing the relationship between the statutory partner agencies in terms of the Women's Health Working Group and the Women's Health Policy to Hudson *et al.*'s (1997) 'collaborative continuum', it is clear that it relates most closely to the 'communication' point on this continuum, with periodic examples of collaboration, for example Centre for Women's Health and the development of the Policy itself. Whilst a number of examples of action developed by the WHWG and its subgroups were identified, this collaboration did not generally extend outwith the fora in terms of broader collaborative working between the organisations.

Whilst clear motivations for multi-agency working were highlighted by many members of the WHWG, such drivers were not apparent within the organisational women's fora, or within the broader organisations. In discussing the perceived enablers to multi-agency working in general, interviewees highlighted four key factors: necessity, organisational support; agency; and strategy. When these factors are compared to the perceived enablers to the implementation of the Policy, necessity is the one issue not included. This is perhaps the key distinction between the development and the implementation of the Policy: whilst the WHWG clearly felt there was a need for a WHP, and there were many supportive people within the organisations, such a 'need' to implement the Policy within and between organisations was not necessarily seen outside this core group. As such, it may be argued that there was a gap in the perceived 'collaborative advantage' (Huxham, 1996) to be gained between the WHWG and the partner organisations. This issue will be explored further in Chapter 6.

5.7 Summary

In conclusion, a range of enablers were identified by interviewees for the implementation of the Women's Health Policy within the statutory partner agencies. These include: the legitimisation of the policy as a result of its development in consultation with women in the community; the multi-agency approach which was characterised as acting as a lever to the adoption of the Women's Health Policy and the establishment of the Centre for Women's Health; and the breadth of the definition of health making the Policy of relevance to all agencies. Additional levers included the development of structures within the organisations, the presence of senior and political support within the organisations and the

agency and commitment of individual members. In the next chapter, the perceived barriers to the implementation of the Policy are explored.

Chapter 6 - Implementing the Glasgow Women's Health Policy: Barriers

6.1 Introduction

Within the preceding chapters, a range of action relating to the implementation of the WHP has been identified. However, it has been clear through the accounts of interviewees and the documentary analysis that difficulties were experienced in connection with some areas of planned action. Some key informants highlighted the problems they had encountered, and some were dissatisfied or frustrated with the limited amount of action that had taken place. Within this chapter the interviewees' perceptions of the factors or circumstances that have acted as barriers to the implementation of the WHP are explored. Such perceptions of the particular case are compared against their understandings and experiences of multi-agency working in general.

6.2 Barriers to implementing the Women's Health Policy

The most frequently highlighted barriers by interviewees for each of the statutory partner organisations concerned issues relating to the organisations themselves, the way the organisations work, their systems, processes, structures and culture. A review of all of these issues led to the development of nine broad categories: limitations of the Policy; 'women's' policy; 'women's' structures; lack of power and organisational support; health; organisational structures; organisational process; organisational culture; and context. Each will be analysed in turn, beginning with those most closely related to the Policy itself and the mechanisms devised for its implementation. In many cases cross-cutting themes exist within these categories due to the inter-relationship between culture, structure and process.

6.2.1 Limitations of the policy document

A common criticism of the Policy as a document was that it was not specific enough in terms of what it was asking the organisations to do. Some interviewees felt that the policy

was too broad or too vague and did not comprise of any targets for action which could be identified or adopted by the organisations.

It's probably all things to all women if not all people! I think it's maybe not specific enough in terms of the action...I think the recommendations are far too broad, I think they're also very easy for people to say, 'Well that's too expensive, it's too difficult'. I think there are a range of excuses that can be brought into play there. (SRC, Interviewee 17)

For some interviewees the Policy was not radical enough, as they considered it did not make explicit what the problems were in the present situation, both in relation to the needs of women and the impediments within the existing practice of organisations, although as one interviewee noted this could have been tactical.

I suppose in some ways it was a very soft policy. It didn't, and maybe that was deliberate as well, it didn't condemn a lot. There wasn't a lot of condemnation about the services that are already there (SRC Interviewee 10)

Related to this a further limitation identified by some interviewees with the document was that it did not reflect the diversity amongst women, that in seeking to address all women it had submerged the needs of particular groups such as the disabled, ethnic minorities etc.

One of my criticisms of the Policy when it came out... was that it didn't make particular mention of particular needs groups, like Black women and lesbians and women with disabilities, and I think it could have been stronger on that. It was a bit weak when it just talked about women. (SRC Interviewee 12)

A number of Glasgow Healthy City Project perceived the Policy to demonstrate a confusion between women and gender. For example,

I think the Policy kind of fell between two stools. If it had been a policy about gender then it could have addressed more fully an agenda which was about power relationships and all those kinds of things in terms of relationships between men and women. (GDC Interviewee 2)

A further issue regarding the content of the Policy concerned the lack of inclusion of poverty and class issues. Concern was raised that the Policy did not reflect the reality or the priorities of women in Glasgow. Some interviewees commented that the inclusion of poverty and environmental issues may have improved the acceptance of the Women's Health Policy, in Glasgow District Council in particular.

There wasn't nearly enough in it about poverty, not nearly enough and it wasn't highlighted in any significant way... in the Glasgow context to have a policy about anything which doesn't give a prominent role to poverty is mistaken. I think that most of the people whose needs are not being met in Glasgow have an element of poverty... You'd have got much more support, practical support within the organisations if poverty had been highlighted because the organisations could have worked with that, the individuals within the organisations could have lived with that much more easily than they could have lived with a policy about women. (GDC Interviewee 2)

A number of interviewees questioned the intended target of the Policy. For some the Policy was seen as too middle-class or 'preached to the converted'; others that there was not sufficient community involvement, whilst others again thought that the Policy concentrated too much on service users and should concentrate more on employees first.

It's quite sad. Why do we promote all this outside when we've got the very people we're wanting to help working for us? (GDC Interviewee 5)

Some interviewees felt that the Policy contained too much of a focus on health care provision. They related this, in part, to the genesis of the Women's Health Working Group from the Clydeside Women's Health Campaign which, as discussed in Chapter 4, campaigned largely on health service issues. As such, some interviewees felt that the Policy had not fully realised the potential of pursuing action in other areas.

Thus several perceived limitations of the Policy document in terms of the 'problem representation' (Bacchi, 1999) were highlighted by the interviewees which they considered to present obstacles to its implementation: the breadth and ambiguity of the policy and the lack of targets; the 'health care' focus and lack of inclusion of poverty issues; and the conception of 'women' as a homogenous group rather than reflecting the diversity of experience. An additional and related issue of the labelling of the Policy as 'women's' is discussed below.

6.2.2 A 'Women's' Policy?

The most frequently highlighted perceived barrier to the implementation of the Women's Health Policy within the organisations related to the labelling of the document as a 'women's policy'. This issue is closely related to issues of organisational structure and

culture, as will be discussed later, but was such a common response that it is discussed separately. In being labelled as a 'women's policy' many interviewees had felt that this had led to the Women's Health Policy being marginalised within their organisations. This perception was held both by those supportive of having a women's policy and those not supportive. Marginalisation was considered to result from both structural and cultural factors. Structural marginalisation was perceived to result from the tendency of senior managers to pass on the responsibility for Policy to an individual in the department/organisation who was without the appropriate power or remit to act on it, rather than it being taken on centrally or at a senior level. A WHWG member commented:

I think what happens is that when it goes out to departments people immediately go 'well it says women on it' and therefore it will go to a very small number of people within that department...not a particularly appropriate or strategic person, but someone who has an interest in gender equality or women's health, and I think that's a problem. (SRC Interviewee 7)

In relation to the organisational culture, some interviewees perceived the Policy to be considered 'threatening' to men. As the Policy presented a challenge to the status quo, it had met with defensive response and resistance within the organisation. Several interviewees commented that a common reaction to the Policy being raised as an issue was 'What about men's health?'. A WHWG member commented:

If I had a pound for every time people said, 'What about a men's health policy? What about a men's health centre?' I would be extremely rich. (GGHB Interviewee 9)

A few interviewees commented that there had been a general 'backlash' about all forms of equality initiatives. Others highlighted that this was particularly the case in relation to 'women's' issues, due to 'fear of feminism'. As one interviewee commented, tackling other equality issues in the city, such as race, was much less threatening to men's power base than addressing women's issues.

If you are white, male and relatively privileged in a city where under 5% of the population are black then you are doing magnanimous good things without compromising their own position, whereas gender strikes home more. (GDC Interviewee 10)

Several interviewees also commented with surprised dismay at the reluctance of women within the organisations to become involved or support the implementation of the Policy. For some this was seen to result from the persistence of traditional views of gender roles and women's status within the organisations, whilst more frequently it was seen as deriving from a reticence amongst women to be seen as requiring special attention. In terms of the reluctance amongst more senior women, some interviewees perceived them to have a lack of appreciation of the barriers facing women in life and within the organisations.

Sometimes there are also difficulties because women when they get into positions of influencing policy or making policy and driving in the power seat don't necessarily hold the women's issues value. They sometimes behave and adopt a power base quite like men. (SRC Interviewee 17e)

This relates to issues raised by Bacchi (1999) and Rees (1999) in relation to positive action policies. Whilst a few interviewees suggested that they were aware of or had experienced active resistance to the Policy in some quarters, others characterised the reaction as one of apathy or disinterest, adding that the Policy was not considered to be a priority or key document.

I'd hate to say disinterest, but I mean there certainly wasn't great enthusiasm and wasn't really seen to be, in my view, it wasn't seen to have a high priority in the great scale of things. (GGHB Trust Interviewee 8)

I think the issue is certainly seen as a frill... it's at the bottom of a pile of things to be done when you've got to get people off the waiting lists and operated on. (GGHB Interviewee 4)

This relates to the marginalisation of the category 'women' within the dominant discourse as outlined by Bacchi (1996). As indicated in Chapter 5, whilst the majority of interviewees perceived there to be a need for a separate women's health policy, some were concerned that using such an approach would have a negative impact on the potential for implementation due to the marginalisation of women's issues within the organisations which they considered to be male dominated structurally and culturally. For these interviewees having a generic health policy which included a gender analysis was the preferred strategy of increasing that potential. A number of interviewees commented on the difficulties they had faced in trying to introduce the Policy within their organisations.

It's too focused in some ways on females. It's quite difficult to explain, but most of our consultant colleagues are male and clinical directorates and things like that are male, so it's actually quite difficult to try and not show the bias of the Women's Health Policy, and you get all these sorts of comments about why isn't there a men's health policy (GGHB Trust Interviewee 1)

Other interviewees felt that the approach should be generic, as women's inequality should not be prioritised over other inequalities. A small number of interviewees commented that having a women's health policy made little sense in the absence of a generic holistic health policy, arguing that if there was no health policy from which women are excluded then there is no need for one specifically for women. Others added that there was no need for a separate policy as sufficient policies already existed within their organisations.

You don't necessarily need a separate document but you certainly need some sort of analytic framework which identifies inequalities... I suspect that having the Women's Health Policy as a stand-alone might have reduced the effectiveness, you know you go on about women's health and someone says what about men's health...Whereas if you say something more along the lines of getting the balance right, looking to have race gender and class in a unified fashion you might get further, if you have an equality policy you don't prioritise 50% of the population over the other 50%. (GDC Interviewee 10)

I don't specifically look for a women's health policy, there's a council health and safety policy which covers everybody, and if you're doing it right it should cover everybody. (GDC Interviewee 16)

Thus the implementation of the Women's Health Policy was to an extent seen to be limited by its labelling as a 'women's policy', which was perceived to have resulted in its marginalisation within the organisations and a defensive or disinterested response. This reflects the findings of Cockburn (1991) in terms of resistance to sex equality initiatives within organisations. The reasons presented for the marginalisation and resistance of the Policy concerned the gendered nature of the organisations culture and structures. As such, the establishment of women's fora to oversee the implementation were similarly seen to be disadvantaged, as is discussed below.

6.2.3 'Women's' Structures

Related to the low status accorded to the Women's Health Policy as a 'women's policy' some interviewees considered the development or co-option of 'women's structures' within

the organisations to oversee the implementation of the Policy to have acted as a further barrier to its implementation. Whilst, as discussed within Chapter 5, such fora were seen as important enablers in terms of raising awareness, developing supportive networks and facilitating communication, several interviewees commented that such fora limited the extent of integration with the mainstream policy development of the organisation. As is often the case with individual officers having an explicit remit for 'women's issues', a number of interviewees commented that responsibility for women's issues was seen to be the domain of these fora to the exclusion of them being discussed within other groups or committees. Several interviewees commented that just as they perceived women's issues to be marginalised within their organisations, so too were the women's fora. This was particularly perceived to be the case within GDC and SRC, where the women's fora were considered by many interviewees to be isolated from the main reporting and decision-making structures of the organisation. This was indicated within the documentary analysis of SRC AGoWI and GDC WGWHP, where very few references to the fora were located within the Council minutes. As a result, the debates and action of these fora were not being disseminated within the organisations. One Strathclyde Regional Council interviewee felt that the establishment of the Advisory Group on Women's Issues was an act of tokenism, whilst several others felt that the lack of power of this fora, which lacked committee status, to be a barrier.

If you're not a full committee you don't get into the Council minutes, so therefore you have less and less opportunity to raise issues at sub-committees, full committees and then ultimately the full Council meeting. So there's less and less opportunity for issues contained within the Policy to be discussed and debated within the whole Council. (SRC Interviewee 10)

The establishment of the GDC Women's Committee was not universally supported and a few interviewees commented that they considered the Policy's association with that committee to have impacted negatively on its acceptance.

it was linked to the Women's Committee which had very very bad publicity just because it was a women's committee, they kept spending lots of money on what people thought as feminist issues, so it probably didn't help because it was linked. If they had said it was a health policy for Glasgow and gone down a different committee structure, then it would have been treated much more seriously. (GDC Interviewee 5)

In addition, the lack of status accorded to the women's fora was argued by several interviewees to be evident in the difficulties experienced in securing strategic representation. Interviewees from each of the organisations commented that whilst the fora were not intended to be 'women only' they became so due the reluctance, in the case of GDC and SRC, of male politicians to attend, and the tendency of senior male managers to delegate representation to a less senior, usually less strategic, woman within the department/organisation.

I think it did get bogged down in the fact that it was a women's committee, and it was also disappointing that the councillors ended up being female as well. We tried to encourage male councillors who were just not having it, they just weren't coming along, and that was because it wasn't an equality issue, I think it lost a lot of credence. (GDC Interviewee 12)

There were male members of the group, about three I think, but they didn't come, they sent female substitutes. It's very interesting that you couldn't actually get them, and if you invited a man to come along in his professional capacity they would be very nervous, they didn't like coming, they were uncomfortable with the whole thing. (GGHB Interviewee 6)

The delegation of responsibility for attendance to less senior women was seen as hindering the effectiveness of the fora in relation to decision-making, with some members having to report back to their organisation rather than having the authority to make decisions. As highlighted in Chapter 4, some interviewees had commented that the selection of representatives without the authority to make decisions was quite conscious, with some representatives reporting that they had been instructed not to contribute to the work of the fora unless requested to do so. In addition, the delegation of representation was considered to have resulted in a perceived lack of interest or commitment in some of the members. Indeed some of those members in question indicated that they had not wanted to have involvement with the groups, whilst others frequently commented that their low participation was partly due to a lack of comprehension of what their role should be within the fora, and in relation to the implementation of the Women's Health Policy.

I thought that with being part of that working group that if anyone felt that they knew where it was going and what it was doing, I should be one of those people. I didn't feel like that. (GDC Interviewee 5)

Some feel that the situation within their Trust is so powerless that to get any kind of strategic development on anything is impossible. I don't think people particularly

identify with [the Policy], it doesn't see where its power is, it doesn't see where its influence is particularly well. (GGHB Interviewee 4)

Communication was identified as a problem, particularly the failure of members to feed information into the Working Group and also to report back to their organisations or departments.

It's never been made clear to the employer that by attending the Working Group this woman is expected to have a role within the organisation that she's representing, to take information back and the organisation has some responsibility for seeing whatever they take back gets carried forward. That has never been clarified. (GGHB Interviewee 6)

A further tension raised by some interviewees related to the perceived inequality between members of the fora in relation to power, involvement and responsibility. To some extent this was seen as a facet of the lack of organisational support for the Group as is discussed in the next section. In particular, one GDC interviewee commented, in relation to the Women's Committee, that co-opted members from outside organisations had more involvement than the officers of the Council. This feeling would perhaps have been enhanced by the organisation of committee meetings where only elected members and co-opted members sit at the table, with the officers sitting on chairs away from the table.

I felt that within the Women's Committee there was a huge percentage of District Council Officers that had a tiny, tiny say and it was those external to the Council members that got an awfully big say, I don't quite know who the Policy then was for. (GDC Interviewee 5)

Whilst the various fora were perceived by some interviewees as providing a supportive environment to women, a number of interviewees commented that the fora tend to be 'cosy', comprised of like-minded people and failing to engage in challenging discussions outside their own network. Similarly other interviewees referred to the existence of a 'women's clique' who tend to 'preach to the converted'. A WHWG member commented:

I still think it's really acting as a kind of focal point for people who are already active on women's health issues rather than actually having permeated wider. (SRC, Interviewee 12)

Finally a few interviewees criticised the approach or stance taken by the Women's Health Working Group. Some felt that the group tended to 'take the moral high ground' and were

not open to constructive criticism about the focus or action of the Group, while others criticised what was seen as often a confrontational approach by the Group. In relation to the groups interactions with the Glasgow Healthy City Project one interviewee noted,

They could have been much more involved in the formulation instead of coming to the Healthy Cities Project always with their agenda. No matter what you think are the rights or wrongs of this, tactically they came very close to invoking a backlash, with individuals saying 'I've had enough of this, what about men's health?'. That kind of response was imminent, in fact people said it to me. (GDC, Interviewee 2)

In summary, the establishment of women's fora to oversee the implementation of the Women's Health Policy were considered to hinder the implementation of the Policy within the mainstream workings of the organisations due to the marginalisation of both women's structures and women's issues within the organisations. Marginalisation from decision-making was seen to be increased by the reluctance of senior strategic men to become involved in the fora, and in the case of the two local authorities, prior to the establishment of the GDC women's committee, the lack of power of the fora themselves. In addition, the lack of clarity of the expected roles of the fora representatives in relation to the implementation of the Policy within their organisations was also perceived to impede the extent to which the Policy was implemented within departments. Several of the issues raised within this section relate to a lack of power and organisational support, as discussed below.

6.2.4 Lack of Power/ Organisational support

Related to the perceived marginalisation of women's issues and women's fora within the organisations, many interviewees commented that the relative lack of power of these structures and their members hindered the implementation of the Policy. As discussed in Chapter 5, much of the work in relation to the Policy depended on the agency of a few key individuals with access to power, or the gatekeepers to power, and through informal lobbying rather than being pursued through the designated structure. In the case of SRC in particular, whilst some interviewees suggested that the establishment of the Advisory Group on Women's Issues rather than a women's committee had facilitated its acceptance within the organisations, the failure of the proposed reporting mechanisms led other

interviewees to comment on the reduced ability of the group to communicate formally within the organisation, as previously highlighted.

The lack of power, status and access to channels of communication within the organisation were seen by some interviewees to impact negatively on their ability to pursue work within the organisation. As one interviewee commented on the difficulties experienced in terms of obtaining responses from departments to requests for information,

it was torturous, absolutely torturous, because I think officers from those departments felt that the group did not have any status. It wasn't a full committee so therefore they were reluctant to go away and do the things that this wee sub-group was telling them to do. If it had been the Education Committee a number of those officers would have jumped but because it was only an advisory group there was this reluctance. (SRC Interviewee 10)

The lack of mandate to ensure the implementation of the Policy was highlighted by several interviews, who considered in the absence of statutory requirements or enforced obligation no action would take place. This was seen as being particularly relevant within the context of cutbacks in public sector funding. As a related point, several interviewees considered the implementation to be impeded by the absence of monitoring or evaluation.

I think it's a bit about implementing it, because it's OK when we've got the commitment and there's a clear action plan and everything else, but I'm not quite sure how to come back and monitor that and say 'did we achieve this? and if not why not? (SRC Interviewee 12)

Whilst the WHP had been included within the Trusts' contractual agreements with GGHB, a number of Trust interviewees highlighted that the Policy had not been formally adopted by their organisations. This indicates a lack of ownership and the low status and priority accorded to the document. The relative lack of action within the NHS Trusts was a problem recognised by the GGHB WHPWG and again reflects dependence on key individuals to instigate action rather than the policy being 'picked up' independently.

Other issues concerning power and agency relate to the broader policy context and the apparent limited ability to act on a local scale within a highly structured national policy framework. The accountability of organisations to their public paymasters is frequently

referred to by senior personnel as a reason for the maintenance of closely guarded boundaries and remits.

In relation to organisational support, whilst senior, political and formal support were seen by some interviewees as enablers to the implementation of the Policy, several interviewees also commented that they considered such support to be superficial or limited.

I think there's a lot of tokenism associated...I think most people pick it up and go, 'Oh that's interesting', and it's just put on a shelf. (GGHB Interviewee 3)

At a senior level the Women's Health Policy was not something which was considered seriously. Something like the Housing budget or the Environmental Health budget, the hard stuff, it didn't impinge in any meaningful way on very senior levels of management. (GDC Interviewee 5)

The relative absence of senior commitment in all organisations to the implementation of the Policy was seen to be a considerable barrier, related to the absence of a statutory requirement, to the potential for implementing the Policy. As one Health Board member noted, there was strong sense that the work of the Women's Health Policy Working Group was not taken seriously.

You had this sort of stereotype thing, labelling of the group as if it was a joke, at a very senior level. I have to say at a senior level it was very disappointing. It would be 'off to the Women's Health Working Group are you? Very good, somebody's got to do it'. This was a Board endorsed document but in my experience it was not regarded as a terribly important piece of work. It was something we had to be seen to be doing, and that's very annoying. (GGHB Interviewee 6)

Interviewees from each of the organisations highlighted the lack of resources available to facilitate work on the Policy as evidence of the lack of importance attached to the implementation. A number of illustrations were given in relation to this, such as the inability of the Women's Health Working Group to secure administrative support and the limited funding available. In addition many interviewees raised the issue of the lack of designated time available to them as representatives in order to pursue work in relation to women's health as part of their jobs.

I think most people haven't got dedicated time. I have only half a day per week to spend on women's health and I spend well over that every week on women's

health. I mean it takes a lot of time and if you don't have dedicated time it's very difficult to move things forward. (GGHB, Interviewee 2)

Related to this, several WHWG interviewees considered the lack of a multi-agency co-ordinator to pursue work within the statutory and other member agencies and between meetings, hindered the operation of the group, and the development of action in relation to the Policy. Linked to the issue of departmentalism, as will be discussed later, the absence of a co-ordinator was perceived to have resulted in an over reliance on a small number of committed members to develop action.

the number of people who are actively engaged with the Policy is increasing, but it is still very dependent on this core group of advocates...I wonder the extent of which it would survive if one or two of those people drifted off. (GGHB, Interviewee 1)

Women's officer posts existed within SRC and latterly GDC, who in servicing the women's organisational fora had by association the Women's Health Policy as part of their remit. Within GGHB a Women's Health Policy Co-ordinator was appointed following the adoption of the Policy. Whilst these positions were seen as significant enablers in terms of developing work in relation to the Policy, some interviewees perceived the officers to be in some instances being exclusively relied upon in the absence of others taking responsibility, and additionally marginalised within their organisations.

I wouldn't have (Co-ordinator's) job for all the tea in China because I think she is fighting almost a one-women crusade, or she must feel like that at times, in that there's a tendency for people to switch off and say, 'Oh it's (Co-ordinator) again', like it's nothing that has to involve them. She's the Co-ordinator so that's her job, it's not their job. (GGHB Interviewee 6)

Finally the lack of resources of organisations was presented by many interviewees as a key reason for the limited implementation of the Policy. Local government cut-backs and the perceived added resource implications of the Policy were frequently highlighted across all organisations. However, several Women's Health Working Group interviewees believed that this could be used as a convenient excuse, as implementing the Policy did not necessarily require additional resources, but their reorientation.

I think at the time a lot of people were all saying we haven't got the money to do this, we haven't got the money to do that. But quite a lot of it was, it could have

been put into practice without spending a lot of resources. It was changing people's attitudes rather than spending a lot of money on it. (SRC Interviewee 10)

Thus in summary the relative lack of power of the women's organisational fora and many of their members were seen to hinder the scope for implementing the Policy within the statutory partner organisations. Closely associated with this was the limited organisational support, with senior and political support being characterised as superficial and a tendency not to take to the Policy or the fora seriously. These limitations were further compounded by the absence of a multi-agency co-ordinator, and a lack of designated worker time to enable representatives to pursue work on women's health as part of their job remit.

6.2.5 Concepts of Health

Some interviewees felt that the perceived lack of relevance of a social/holistic model to organisational practice was a barrier to the implementation of the WHP. Within the two local authorities in particular this was expressed as a lack of understanding of the role of the organisation in relation to the central focus of the Policy on 'health'. Some Healthy Cities Project and Women's Health Working Group interviewees highlighted the conceptual barrier of the model of health incorporated in the Policy in contrast to the dominant bio-medical discourse and a health care orientated NHS. In this way, with 'health' being conflated with 'health care', health was not seen by some as being within the remit of their organisation.

I think there is a tendency to think well health isn't anything to do with us. I mean there was definitely that kind of thing within the District Council, 'What are they going on about health for?' So you could get a small number of people saying the right things, but big numbers, you sort of pass them by really. (GDC interviewee 12)

The issue of responsibility also emerged. Whilst one Health Board interviewee commented that the broad definition had been welcomed within her organisation because it shared the responsibility for health, one Strathclyde Regional Council interviewee argued this to be a reason for its limited acceptance within other organisations.

There's a fairly vested interest in really not accepting holistic definitions because otherwise you're sharing responsibility and you're requiring people to work across boundaries and understandings. (SRC, Interviewee 12)

Some interviewees commented that whilst they considered there to be an intellectual understanding and awareness, there was a difficulty in understanding how this could be translated into practice. Those highlighting the problem of the lack of understanding of the definition of health were however quick to point out that they considered the concept of health employed within the Policy to be essential.

Professional cultures and boundaries with their different understandings of health were raised as barriers to the implementation of the Policy. This was seen particularly between health and social care, but also within the Health Board where the emphasis predominantly remains on treatment rather than prevention. One Strathclyde Regional Council representative highlighted the conceptual and language barrier between health and social care, highlighting that although in many cases there is an overlap between social care and public health traditions, 'health' is a word associated with medicine and so therefore not used.

I think conceptual confusion is perpetuated through language continuing to support practice in a really quite fundamental way...I think there is a direct correlation between this absolute confusion about what health is, right back to the setting up of the NHS, to the structure of health and social care, to public health policy. And it's very hard to overcome because it's kind of rarefied in structures and professions. (SRC Interviewee 12)

In a similar way a few of interviewees commented on the general lack of interest in health issues by people until things go wrong.

Women's health, it's like health in general...it's not an issue for people at different stages of their life, they don't think about it until things go wrong. (GDC Interviewee 17)

It may be argued that general focus of organisations on patching rather than preventing, of responding to crises rather than engaging in proactive work, as will be discussed later, limits the potential for a positive policy on health to be established as a priority on the agenda of organisations. It is important to note at this point that although the issue of the lack of understanding of the definition of health was only raised by a small number of interviewees, throughout the course of the interviews this became apparent in many cases

through discussions on the Policy and examples of action or implementation which predominantly focused on health care provision. For example, two senior SRC interviewees highlighted their organisation's commitment to health as having employed a doctor.

In summary implementation of the Policy can be considered to have been impeded by a conceptual confusion as to what 'health' is. This results from a tendency to conflate understandings of 'health' with 'health care'. In addition whilst there was considered to be an intellectual understanding by some, it was suggested that there were difficulties translating such a model into action. A further issue is that of the existence of vested interests in not taking responsibility for the implementation of the Policy.

6.2.6 Organisational Structures

One of the issues most frequently highlighted as a barrier to the implementation of the Women's Health Policy for interviewees from each of the organisations concerned the male dominated structure, both in terms of the political structure within local authorities and in terms of senior personnel. This was seen to be an obstacle in a variety of ways, largely centred around the perception of a lack of understanding and awareness of the gendered nature of the organisations and how they may be disabling to women. The male dominated nature of the organisations was seen as the reason for the superficial commitment and resistance experienced in relation to trying to implement the Policy as highlighted in the preceding section.

The fact that overwhelmingly elected members are male, overwhelmingly chief officers are male, and there is a therefore a feeling that well, 'we won't deal with women's health, it's a kind of soft issue which we'll leave to women much lower down the organisation'. So I think the fact that women haven't been in key positions has hindered it dramatically. (SRC, Interviewee 3)

Related to this some Strathclyde Regional Council and Glasgow District Council interviewees felt that the lack of women politicians and senior women in decision-making positions was also an obstacle to the implementation of the Policy. The issue of male dominated structures relates closely to the perceived sexist culture existing within each of the organisations, as will be discussed later.

Several interviewees raised professional boundaries as impeding the development of the Policy. For example a number of Health Board interviewees perceived the dominance of clinicians within the organisation and a related focus on health care to limit the ability to introduce a social model of health which can be seen as challenging their existing power base. In addition a number of interviewees perceived the centralised and hierarchical nature of their organisation to impede diffusion of policies. Several SRC interviewees highlighted the specific block of middle management to policy implementation.

There was a blockage within middle-management... in some cases I think senior officers did not want this bunch of women telling them what to do...they wouldn't tell you openly but they would feel that and they would make sure that within their remit they would stymie a lot of things. (SRC Interviewee 10)

A few interviewees from each of the organisation felt that the size of the organisations acted as a barrier due to the limited ability to co-ordinate or negotiate activity across all sections. Interviewees across all organisations commented on a lack of intra-organisational communication. One GDC interviewee commented on the plurality of organisations in which people were often moving in several different directions.

An organisation like the size of the Health Board or the Council...they are not monolithic, they're too big, they don't move, everybody doesn't move in the same direction at the same speed at the same time. And there are some people in the organisation who see what the opportunities are and there are some people in the organisation who see the opposite. (GDC Interviewee 2)

Two frequently raised structural barriers concerned departmentalism and multi-agency working. These issues were raised as barriers to policy implementation in general, rather than being specific to the WHP.

6.2.6.1 Departmentalism

For the two local authorities departmentalism emerged as a common theme. Intra-organisational tensions were frequently highlighted. In particular the Chief Executives or Town Clerks departments, where the Women's Units were located, were seen as trying to interfere with the workings of departments. This reflects the findings of Halford (1992). Some interviewees commented that as the Policy had not been developed within their

departments there was a lack of ownership of the issue, whilst other interviewees felt that sufficient existing policies were in place.

It would have to have been something instigated by the department to actually impinge particularly on the department (SRC, Interviewee 1)

Some interviewees also felt that departmentalism extended to a reluctance to co-operate or work together. Others commented that there was a tendency for departments to act defensively rather than positively in response to issues. A manifestation of this was seen to be the lack of departmental support.

There was a tension...the Education Department were perceived by Chief Exec's as going off on its own and not working as part of the Council, not doing as it was told and thinking it was autonomous...the Chief Exec's Department was perceived as having too much control and not letting you do what you wanted and riding roughshod. I think because the Women's Unit was associated with the Chief Executive's department, there was a sense in which there was, shall we say, a somewhat unwilling compliance, yet at other times there would be co-operation. (SRC, Interviewee 1)

Intra-organisational tensions were also highlighted by Greater Glasgow Health Board interviewees as resulting from the purchaser provider split within the NHS and the development of a competitive culture.

What the NHS reforms were set up to do was to create a competitive atmosphere between purchasers and providers and between providers. We always felt that this policy was never going to be implemented in that kind of atmosphere of competition, so we had to kind of fight that by bringing people together and trying to get them to think and work co-operatively. (GGHB Interviewee 9)

A few local authority representatives also raised the issue of the ability of departments or workers to subvert the aims of the policy. This issue relates to both organisational process and culture.

The stated aims and objectives of policies are not always the implemented policy objectives. Between any policy and its implementation there are ten or fifteen people who don't want it to happen or who want something else to happen or have career ambitions or whatever. There's lots of different things that can get in the way of that. (GDC Interviewee 16)

A number of interviewees commented on the pervasiveness of departmentalism within the organisational women's fora with representatives coming to the meeting with different agendas.

They were all fighting their own corners and not particularly working together. If you're there for the Housing Department, you're interested in housing, you represent the department so you must only fight for that department and that's what we're bad at, because I wouldn't give an opinion about housing because it's not my department. (GDC Interviewee 2)

6.2.6.2 Multi-agency working

A range of differences between the organisations were highlighted which were perceived to hinder or complicate multi-agency working. One issue was the difference in size, scale and power between organisations, particularly where voluntary or community groups were part of the process. Smaller groups and organisations were perceived by some interviewees to find meetings intimidating, whilst other interviewees commented on the tendency of some members of larger organisations to try and dominate or control the agenda.

There's also the fear that will it be genuine multi-agency working or will it be about somebody trying to drive that, jockeying for position about who will be the key players and that sort of thing. (SRC Middle level, Female)

The issue of geographic scale was also raised as the organisations did not operate with coterminous boundaries, causing difficulties in defining the population in question. For the statutory sector in particular several interviewees highlighted organisational remits as a barrier to multi-agency working, with organisation having strictly defined statutory requirements and restrictions on their use of funding.

We have directives coming from the Scottish Office that we have to deliver. So even when there is a willingness and an organisational willingness for it there's all things that can pull back into top-down type directives. (GGHB Interviewee 11)

Some interviewees commented on the status of the Policy as an inter-agency initiative as being a barrier to implementation. Here the issue of where initiatives were seen as deriving from and the tendency for them to be associated with particular organisations or departments were seen as leading to a lack of ownership within other organisations or departments. Organisational boundaries and an unwillingness to collaborate was raised by

one GDC interviewee, whilst some Strathclyde Regional Council interviewees commented on the impact of inter-governmental tensions between the two local authorities.

The Regional Council and the District Council did not particularly see eye to eye when they were developing policies and often by virtue of this coming from the District Council you could almost guarantee its rejection by the Regional Council. Much of the multi-disciplinary and partnership work was inhibited or impeded by the 'not invented here' syndrome. (SRC Interviewee 8)

Interviewees also highlighted as barriers the different management structures between organisations and differences in the levels of responsibility and accountability. One senior Health Board interviewee commented that local authorities had a tendency to 'occupy the moral high ground', as they were directly elected by the population rather than appointed. A senior SRC representative commented on a lack of strategic working within his organisation and a history of bad working practice.

The history of corporate working...was not a good system, I mean it was a very, very artificial corporate policy we had. (SRC, Interviewee 8)

The unequal commitment of participating organisations was highlighted as a barrier to multi-agency working by several interviewees. For some interviewees this was seen to result from the dominance of an organisation's own goals and agendas over those of the multi-agency group. Others, who highlighted individual's commitment and determination as an enabler to multi-agency working, highlighted the problem of a lack of continuity of staffing, particularly the case with local government reorganisation and the leaving of key personnel. This necessitated continued networking, the rebuilding of links, and renegotiating activity.

Defensiveness or protectionism was a common theme amongst the interviewees both in terms of organisational and departmental boundaries, particularly for GDC and SRC interviewees. One senior GDC interviewee commented on the problem of representatives coming to the multi-agency table with their 'organisational hats' on rather than as 'contributors to the bigger picture'. A senior SRC interviewee referred to the problem as 'organisational jealousy', with particular organisations wanting to take the responsibility or credit for particular initiatives rather than sharing it with others. The GHCP provides a clear example of this. For some the Project lacked power because of its inter-agency

status, whilst for others the barrier was that it was seen as a GDC initiative, because although it was funded by each of the organisations it was located at the District Council and the staff were on their payroll.

The relationship of the Women's Health Working Group and the Policy to the Glasgow Healthy City Project was raised by a number of interviewees. A few SRC representatives commented on the origin and development of work on women's health in Glasgow, arguing that its genesis outside the Healthy Cities Project led to the Women's Health Working Group remaining largely independent of the Project and left to its own devices rather than being included as a priority.

Because of the structural problems about the Healthy Cities Project and women's health, that they're not particularly focused on the women's health issues, and there's been enormous problems about that relationship. (SRC Interviewee 14)

A number of operational weaknesses were raised by Women's Health Working Group interviewees relating to the multi-agency nature of the Group. A number of interviewees considered the number of different professional backgrounds represented to have created a lack of cohesiveness or clear focus within the Working Group

I think a few members were quite blinkered, that their area was the only thing that was going to make a difference... that their area of work should receive more funding and that they were the priority (GDC Interviewee 9)

I think it's quite difficult when people come together in a Group as diverse as that, because you're not just coming from a professional background in social work, or medicine or health visiting or from a voluntary group, you're coming with you're own set of values and philosophy, background, training, expertise. (SRC Interviewee 17)

Some interviewees felt that there was a lack of trust between group members of different organisation, and sometimes less than open sharing of information. A few interviewees commented that despite it being a multi-agency forum there was a lack of direct collaboration between the organisations and a tendency for particular organisations to claim ownership of initiatives.

There was quite a lot of coming together, but there wasn't as much collaboration as they could have been... it could have been better in terms of trying to get things

like joint funding for pieces of work. That wasn't always possible, it was either one organisation was going to do it and then it became their baby, or else it wasn't really done at all. (GDC, Interviewee 12)

Others commented that a barrier to multi-agency working is quite simply that people do not know how to do it.

The lack of understanding is part of the problem, the fact that we don't know how to work across agencies very well. You can't just bring agencies into a room and expect them to work together, they actually need help to bring that process to fruition. (GGHB Interviewee 9)

In summary, the male dominated hierarchical structures of the organisations have been argued to form a barrier to the implementation of the Women's Health Policy due to the lack of appreciation of the gendered nature of the organisations. Departmentalism has been argued to restrict the implementation of the Policy due to the location of the Policy within centrally based structures and an unwillingness of departments to respond to what they consider to be outside interference. Intra-organisational tensions were matched by inter-organisational tensions, experienced within the Women's Health Working Group. Key issues include power, ownership, trust and communication.

6.2.7 Organisational Process

'Organisational process' refers to the predominant forms of working within organisations, and is associated with organisational structures and cultures. Some interviewees perceived barriers to implementation as deriving from the implementation process of the Women's Health Policy in particular, and also from the policy process in general. The policy process is the arena of the barriers, but their existence stems from the organisational structures and culture. One of the suggested explanations for the limited implementation of the document was its nature, being a long-term strategy in organisations based on short-termism. Other barriers highlighted by interviewees referred to organisational working practices. One issue raised by interviewees from each of the organisations was that of different planning time-scales, particularly financial time-scales. Several interviewees raised this issue in relation to differences between social work and the NHS, citing the example of community care.

Different planning horizons, I mean community care is over three years, and Health Board plans are done on a year by year basis, things like that. (GGHB Interviewee 10)

Interviewees also commented on the problem of 'spend or lose' budget arrangements which were considered to limit the opportunity for strategic planning and to create a 'rush to spend' at the end of the financial year. Concerns about funding were seen by some interviewees as creating a 'distraction' from long-term goals, whilst others perceived the limited funds of organisations to lead to a defensive approach regarding their own funds, and sometimes a suspicion that a motive for working together was an attempt to shift costs onto another organisation.

A number of interviewees commented on the negative impact of the policy process which tends to be lengthy and incremental. Related to this is the lack of ability to monitor effectively what happens to a policy once it has been written. This was something frequently raised by interviewees in relation to the implementation of the Women's Health Policy. Many commented that after the dissemination of the policy to departments they had no knowledge of what had taken place.

Whether we could make sure everything was implemented was another matter. I think it's a bit hit or miss sometimes. You think you've convinced people that's what they should be doing and then six months later you discover that they abandoned it the next week or something. (SRC, Interviewee 7)

Other interviewees discussed as a common weakness in policy implementation the tendency for the existence of a policy to be seen as sufficient action on an issue, specifically that effort put in to writing a policy is not matched in the implementation. The policy development and policy implementation in practice was also raised. Some interviewees commented that organisations in general were notoriously bad at implementing policies because the people responsible for writing policies did not have to implement them. Others commented that they considered there to be an intellectual understanding of the issues but a lack of knowledge about how to translate that understanding into action or practice.

If I have a criticism of most policy documents in local authorities, they are not very specific... they fall down by not translating desirable principles into specific activities... often of course because they are written by policy people who don't

actually have to do anything so they don't get implemented properly. (GDC Interviewee 7)

Each of the organisations were portrayed by some interviewees as being traditional and reactive, operating within a climate of crisis management rather than developmental or proactive work. One GDC interviewee commented on the nature of her organisation being largely funding driven, influencing the type and scope of work that was undertaken.

We tend to be very funding driven, so if there isn't funding for doing things like tackle health then we're not all that likely to do that, you know. (GDC Interviewee 9)

In summary a number of facets of organisational working and the policy process in general may be seen to have hindered the implementation of the Women's Health Policy, in common with all policies.

6.2.8 Organisational Culture

For many of the interviewees the Policy's main aim was trying to achieve cultural change. As such a barrier to its immediate implementation was seen to be in the necessity but difficulty of trying to achieve that. Several interviewees from each of the organisations felt that a male or sexist culture operated within their organisations. This related to the male dominated nature of their organisations and was felt to have resulted in a marginalisation of women's issues. The existence of a range of informal networks of senior men was also raised.

I felt they were always quite chauvinistic, very much the old boy network and what do we need this policy for, and all that kind of thing. (GDC Interviewee 5)

The influence of culture was highlighted by interviewees across all organisations, and by both males and females. One SRC interviewee highlighted the male culture within organisations which is so established that it is taken for granted.

Because our world is still sexist and the socialisation of gender is so profound...men do not think that they are thinking gender specifically because it's like the world is defined either explicitly or indirectly as male. So when men talk about the world they are talking about the male world primarily. (SRC Interviewee 12)

Some local authority interviewees, particularly those from the Glasgow District Council felt that the cultural barrier was particularly strong in Glasgow. The Glasgow culture was seen as being traditional, paternalistic and macho. One GDC interviewee linked the barriers to the implementation of the Policy within his organisation as stemming from its development as the main employer of Catholics in Glasgow due to the prevalence of sectarianism, and the associated beliefs.

The Labour party in Glasgow was formed by immigrant Irish labourers, that makes it a predominantly Catholic organisation... which makes it very, very difficult to get everyone on board on particular issues. The Labour Council in Glasgow is still against abortion for example. That is the kind of organisation in which you are trying to introduce a policy about women. (GDC Interviewee 2)

Class was similarly raised by some local authorities as an issue, with Glasgow portrayed as a working class city with a strong tradition of trade unionism. The Policy was seen to suffer from being viewed as a middle-class document and not reflecting the reality for the majority of the city.

Contrasting organisational cultures were seen as a barrier to multi-agency working in general, as were differing professional cultures. This was an issue highlighted in particular by Health Board and Strathclyde Regional Council interviewees, a common problem being differing cultures of social work and medical professions. The dominance of the bio-medical model of health within the NHS was highlighted by some Greater Glasgow Health Board interviewees.

I think the NHS feels that it's about operations, drugs, doctors, nurses, throughput, finished consultant episodes, things that the Minister can stand up on TV and say, 'We're treating an extra 9000 people this month'. The fact that we may be treating them for completely the wrong thing and what we should actually be doing is doing something about their damp housing is by the by. (GGHB Interviewee 10)

Other interviewees highlighted the developing competitive culture within organisations with the introduction of internal and external markets into public sector organisations limiting the potential for the Women's Health Policy, indeed any policy based on building co-operation and collaboration to be successfully implemented. As one interviewee commented in relation to NHS reforms and the creation of quasi-markets:

It has been very slow to get to any position of strength because of the prevailing circumstances. You know, when Trusts are pitched against one another for everything else, yet we are expecting them to sit down and work together co-operatively to work out how they can take forward an issue which they haven't got the slightest bit of interest in. (GGHB Interviewee 9)

6.2.9 Contextual

Contextual issues refer to those changes taking place during the period of analysis which have impacted on the specific circumstances within which the implementation process took place. Organisational restructuring was a barrier highlighted by several interviewees. For local authority interviewees this was presented as the impact of local government reorganisation which had hindered the implementation through a focus on establishing the new authority, the loss of key individuals and the need to establish new structures and networks. The subsequent departmental restructuring after the establishment of the new authority was seen as causing an additional delay to the implementation of the Policy. In a similar way the development of new structures within the NHS Trusts as a result of the restructuring of the NHS was seen as an obstacle to the implementation of the Policy by some Trust representatives.

A lack of resources was also an issue raised by interviewees. A general squeeze on funding through local government cutbacks and the constraints on the NHS were seen as a barrier to implementation, although as previously mentioned several Women's Health Working Group representatives felt that this was often a convenient excuse and a misunderstanding of what the implementation of the Policy required. Several local authority interviewees feared for the impact of this on the voluntary sector, that cutbacks would be made on a 'women first' basis.

Despite all the problems and barriers highlighted and some negative views on the status of multi-agency working, some interviewees continued to express the view that the benefits far outweighed the multitude of obstacles that could be encountered.

I would still argue at the end of the day that it's a better process even if at the end of the day you can't find a solution that pleases everyone, you just can't find it...the very process of trying to work together you at least avoid a lot of the

*continuing damage that can be done through a breakdown in communication.
(SRC Interviewee 18)*

6.3 Discussion

Within this chapter a range of perceived barriers to the implementation of the Women's Health Policy have been identified. In this section, the key issues emerging from the analysis are related to themes arising within the literature.

For some interviewees, the 'problem representation' (Bacchi, 1999) contained within the Policy impeded its implementation within the statutory partner organisations. The breadth and ambiguity of the policy, for example the lack of inclusion of poverty issues, the tendency to focus on health care issues, and the absence of any representation of the diversity amongst women, are argued to have restricted its relevance or acceptance by some groups. Such barriers have been argued as being compounded by a lack of power and organisational support to implement the Policy, and various aspects of organisational structures, cultures and processes.

In comparing the findings of this research with the literature reviewed in Chapter 2, it is clear that many of the issues raised bear a close resemblance to general limitations experienced in seeking to implement policies within organisations, such as: conflicts of interests, inter-organisational tensions, departmentalism, subversion of aims, lack of monitoring, lack of communication, and a lack of resources. The findings certainly support feminist analyses which highlight the importance of power and interests in policy development and implementation in contrast to the presumed objectivity and rationality in traditional accounts of policy analysis (Hawkesworth, 1994). Similarly the analysis has highlighted the difficulties associated with pursuing change within structures and systems that are highly gendered and reinforce inequality (Cockburn, 1991). The research findings broadly reflect the barriers identified within the literature relating to the implementation of gender inclusion policies within single organisations, including: the structural isolation and lack of status of women's structures; limited organisational support and departmentalism;

organisational processes; an absence of monitoring; and male dominated organisational cultures (Stone, 1988; Cockburn, 1991; Halford, 1992).

In relation to multi-agency working, the research findings also broadly correspond to issues raised within the literature. Whilst in Chapter 5, multi-agency working was characterised as an important enabler to the development of the WHP, difficulties with multi-agency working in action were similarly seen as a barrier to the implementation of the WHP within organisations. Organisational boundaries and protectionism; departmentalism; organisational and professional cultures; competition; and difficulties in operationalising collaborative working have all been highlighted. In addition, the lack of commitment of participants, particularly in a situation where the involvement was considered to be coerced was seen by interviewees to present an obstacle to multi-agency working. This again relates to the defensive and protectionist response of organisations and departments and the lack of trust. Such issues reflect Huxham's (1993) concept of 'collaborative inertia'.

Whilst the research findings broadly reflect issues arising within the literature, three key issues have emerged as being particularly relevant to the implementation of the WHP. Firstly, its status as a 'women's' policy; secondly, the social/holistic model of health; and finally, its status as a local and voluntary multi-agency initiative.

The labelling of the Policy as 'women's' and its co-ordination through 'women's' structures were raised by the interviewees as perceived barriers to its implementation. The perceived need for the Policy and the associated structures arose through the neglect of these issues within the mainstream. However, following Bacchi (1999) whilst the adoption of the Policy demonstrates that 'women's health' had achieved 'problem status', this was not in itself a success or a commitment to change. Central to this is the marginalisation of the category 'women' within dominant discourse, leading to the position where 'women's issues' are seen as peripheral to the policies and practices of organisations. This marginalisation translates into the perceived tokenistic response to 'women's' issues and superficial support within organisations, and may arguably be reflected in the limited development of work relating to the WHP other than that instigated by key individuals within the organisations. The marginalisation of the category 'women' is suggested to be

perpetuated through the relative lack of power of women to inform the dominant discourse due to their relative absence in senior decision-making positions. With the need to address such structural barriers, it is argued that it is necessary to both highlight the social construction of the category 'women' and to challenge the meaning and value ascribed to the category within dominant discourse.

One question emerging from this analysis is whether the implementation of the WHP would have been improved had the issues been presented differently. The Policy could have focused on gender inequality rather than gender difference, or have been labelled a gender rather than a women's policy. As Bacchi (1999) notes the concept of 'women's inequality' imposes a 'man/woman' frame which leaves a range of issues unproblematised, such as the differences in 'disadvantage' among women; and the appropriateness of the structures for all. Whilst arguing for the need to recognise the diversity amongst women and to recognise the social construction of 'female' and 'male' gender roles, due to the pervasiveness of deeply embedded notions of 'male' and 'female' gender roles and behaviour is such that it may be argued that a generic policy or a 'gender' policy would not have significantly improved the potential for the Policy to be implemented. A policy promoting equality by its nature highlights inequality and thus acts as a challenge to the status quo. Having a 'gender'-labelled document may have better represented the diversity amongst women and men and strengthened the argument, but is *unlikely* to have made the issue more accepted.

Related to this is the perceived marginalisation of a social/holistic model of health in relation to the dominant biomedical paradigm, which is reinforced through the power of the professions and functionally differentiated organisations. In addition, the breadth of the model may be argued to hold practical problems for implementation (Duhl, 1992). These issues are demonstrated in the perceived lack of relevance of such a model as contained within the WHP to the day-to-day operation of organisations, and the existence of vested interests against organisations taking a responsibility for the implementation of the WHP.

Finally, it is surprising that, given the general context of the interview, only a small minority of interviewees highlighted the Women's Health Working Group or the work

established as a result of the Policy as being multi-agency working. This may reflect the fact that many interviewees did not consider the work of the Women's Health Working Group or work in relation to the Policy to be multi-agency working, or simply that they were not aware of what work was taking place, or had other more particular examples that they were more closely involved with. Significantly, when questioned, several members of the WHWG said that they were not involved in multi-agency working. This raises interesting questions both relating to the ownership of the WHP, and what is considered to be multi-agency working. Perhaps this reflects the fact that, for the vast majority of interviewees, the implementation of the WHP was not part of their specific remit or responsibilities of employment.

A tension has emerged throughout this and previous chapters between the WHP as being a local, bottom-up and voluntary development, and the capacity for achieving change within organisations. Such tensions reflect a general concern with the Healthy Cities movement, that many areas of policy and decision-making which require change in order for a holistic model of health to be implemented are outwith the control of local initiatives (Hancock, 1993). In addition, the WHP and the WHWG are essentially 'bottom-up' and voluntary initiatives, developing within a grassroots movement, and being participatory and flexible. Whilst, due to the aforementioned marginalisation of 'women's' issues within organisations, the WHP is by necessity bottom-up and voluntary, the absence of a direction or requirement limited the scope for implementation within the organisations. Within their discussions of multi-agency working several interviewees highlighted the perceived importance of financial and other incentives in order for organisations to establish inter-organisational working. It was also considered to be important that the membership of such initiatives should be sufficiently senior with the authority to make decisions. This reflects the findings of a number of authors (Arblaster *et al.* 1996; Hambleton *et al.* 1995). However interviewees highlighted organisations and members being coerced into a multi-agency relationship as barriers, commenting on problems resulting from a lack of organisational support and trust, and the ability of members to stymie or subvert the aims of the initiative in the absence of shared goals and visions. Differentials of power and interests may be argued to be a significant impediment. This reflects the suggestion by

Huxham (1993a) that collaboration will not occur if ownership is not developed through a co-operative and voluntary approach.

The development of ownership of interagency work, of shared aims and responsibilities were all highlighted by interviewees as crucial enablers to multi-agency working. However, working against this were fundamental differences in organisational and professional cultures, of status, power and agency, evident in accounts of multi-agency working as threatening, and of the distrust and scepticism of the intentions of other organisations. Thus whilst coercion may lead to subversion, the perception of organisations characterised by rivalries, protectionism and suspicion begs the question of how bottom-up or voluntary collaborations can be developed in any meaningful way. Such barriers are arguably further exacerbated by the fragmentation of organisations and the introduction of a culture of competition into the public sector.

In relation to the implementation of the Women's Health Policy, the analysis suggests that a voluntary approach was necessary due to the absence of a social model of women's health as an issue on the agenda of national or local organisations. There were no incentives and no statutory requirements for such a policy to be in place. It was also desirable given the emphasis within a social model and the women's health movement for participation. Whilst the lack of mandate presents an obstacle to its implementation, as is the case with multi-agency working generally, this can be argued to disguise the unwillingness of members of the organisations to work co-operatively.

The findings of this research reflect the views of Friend *et al.* (1974) and Webb (1991) of the importance of reticulists to the development of relationships between organisations. This has been evident in the implementation of the WHP through the existence of key senior individuals willing and able to work across boundaries for the promotion of women's health in Glasgow.

In addition, to support a bottom-up voluntary approach, it is argued that there is the need for national policy and legislative support to prevent such initiatives becoming 'token gestures' (Hague 1997) or symbolic policies disguising a lack of real action. The danger of

this is the centre using the networks to impose top-down their view rather than one derived from local needs (Hambleton *et al.* 1995). However as is evident from this analysis of the implementation of the WHP, some level of incentive or direction would be beneficial in order to improve the level of implementation. As Hudson *et al.* note,

effective inter-professional collaboration is a product of local networks based upon co-operation, trust and mutual respect, and that these characteristics cannot be conjured up administrative fiat. What the centre can do is to create a legal and financial framework which facilitates such networking. (1997:30)

Despite all the obstacles highlighted within this and previous chapters as barriers to the implementation of the Women's Health Policy, a level of change has occurred within the organisations which would not have materialised without the determination and commitment of members of the Women's Health Working Group in developing a policy and seeking its implementation within statutory sector organisations in Glasgow. The intention of this thesis in developing an understanding of the processes involved in multi-agency working and implementing a social model of women's health within organisations has been to identify the strengths and weaknesses, opportunities and threats as a means to improving the successful implementation of policies. Whilst the barriers may be seen to be deeply embedded and the enablers contingent, the difficulties associated with multi-agency working and the implementation of the Women's Health Policy do not negate the potential value of the process.

6.4 Summary

This chapter has explored the perceived barriers to the implementation of the WHP within the statutory sector organisations. The barriers identified relate to issues of power, interest, culture and structure, and highlighted the marginalisation of 'women's' issues necessitating a voluntary and bottom-up approach, which in turn can be seen as inhibiting action. Thus the lack of power, culturally and structurally, to define what issues are to be considered a priority, and to ensure implementation within organisations, can be seen as the fundamental barrier the further implementation of the Women's Health Policy. In the following chapter the main conclusions and recommendations arising from the research are presented.

Chapter 7 - Drawing conclusions

7.1 Introduction

The research in this thesis has analysed the implementation of the Glasgow Women's Health Policy as a case-study of multi-agency working. This Policy has been identified as a unique attempt to implement a social/holistic model of women's health within local agencies in the UK, and the analysis has contributed to the under-researched area of the gendered dimensions of multi-agency working. The research aims identified in Chapter 1 of this thesis - extent of implementation, the enablers and barriers to the implementation process, and the process of multi-agency working - have been explored throughout this thesis. This final chapter draws together the 'answers' to these questions, and identifies the central themes which emerged from the analysis. First, the research aims will be addressed in turn, followed by a review of the central themes. The final section outlines a series of recommendations regarding policy implementation and multi-agency working based on this analysis, as well as a range of issues for future research.

7.2 Aim1: Extent of implementation

In seeking to examine the extent to which the Women's Health Policy had been adopted and implemented by the statutory sector partner agencies of the Glasgow Healthy City Project, the intention has not been to evaluate the 'effectiveness' of the Policy adopting a rationalist or 'top-down' model to policy evaluation. Rather, the extent of implementation has been analysed through interviewees' perceptions, and 'tracking' the implementation process and the development of action through documentary analysis. This is the preferred approach because the aim of the research was to assess implementation processes rather than outcomes.

As explored in Chapter 5, a range of action has been identified in relation to the implementation of the Policy within the statutory sector organisations. The WHP was formally adopted by the organisations when it was launched in 1992 and subsequently each of the four 'Priorities for Action' were realised: fora were identified to oversee the

implementation; awareness training took place, although with differing degrees of success at a senior level; representation to the Women's Health Working Group was secured; and perhaps most significantly, multi-agency funding was obtained for the establishment of the Centre for Women's Health. Chapter 5 explored in some detail the work undertaken by the Women's Health Working Group and the organisational women's fora. Common elements among these fora included the production of research and information, awareness raising and responding to policy consultation documents. However, differences emerged in the processes and strategies developed, particularly between GGHB and the two local authorities.

Within GGHB the focus was on seeking to secure action within the mainstream structures and services of the organisation, for example the successful lobbying for the inclusion of the WHP within the contractual service agreements with the NHS Trusts, for the expansion of the Ballantay Model Well Woman Clinics, and in the development of research projects, for example on domestic violence, in collaboration with NHS Trusts. Such action was enabled by the existence of a number of individuals with an explicit remit for women's health and who had access to power, most notably the Women's Health Policy Co-ordinator, the Consultant in Public Health and a Senior Health Promotion Officer. Additionally, this work was facilitated by the existence of a Women's Health Team in developing research and information and an established history of work relating to women's health within the organisation.

The different approach taken within GDC and SRC stemmed in part from the structure of the organisations. Both authorities were much larger and more functionally differentiated than the GGHB. In addition, 'health' of any model was not traditionally a central concern within the organisations, although their potential in health creation was recognised in some areas. The process associated with the implementation of the WHP within both organisations began with departmental consultations to establish priorities for action, in contrast to the centrally defined priorities by the GGHB WHPWG. Within the GDC in particular, this process led to a focus on a narrow medical view of health, and on employee and personnel issues rather than on service provision. Whilst the development of the WHP was seen as important in creating the climate for the eventual establishment of the

Women's Committee, little else by way of outcomes was evident within the documentary analysis. In the case of SRC the women's fora had been established prior to the adoption of the WHP and had an established record of developing and promoting work on gender equality issues, for example poverty, employment and training and women in decision-making. The WHP consultation exercise, in a similar way to GDC, produced responses centring on health care and personnel issues, although the Groups continued to work to a broader agenda. Whilst little action was evident as resulting from the adoption of the Policy, it was credited with providing a focus to existing work within the organisation. In both GDC and SRC the work was seen as facilitated by a core group of women councillors and officers.

In conclusion, the extent of action varied between the organisations, and generally supported and legitimated existing work rather than leading directly to new developments. As such, the WHP acted as an important lever within the organisations. However, in each of the agencies, the work established was instigated by key individuals within the fora rather than the Policy being pursued independently within the mainstream of the organisations.

7.3 Aim 2: Enablers and Barriers to the implementation of the Women's Health Policy

Throughout the preceding analysis a range of issues have been identified that in many cases acted as both enablers and barriers to the implementation of the Women's Health Policy. The research findings demonstrate the inter-relationships between concepts, language and culture, power, structure and agency. Key issues include concepts of health, the category 'women', organisational culture and structures, and power and agency.

The social/holistic model of health employed in the WHP was both an enabler and a barrier to the implementation of the Policy. The establishment of the Glasgow Healthy City Project undoubtedly provided an important opportunity for the development of action on women's health to move from a position 'outside' to 'inside' the organisations. The GHCP provided the opportunity for debates on a broader model of health within the statutory partner organisations, and the implicit principles of equity and participation in particular

legitimised the inclusion of 'women' within those debates. In some instances this enabled the consideration of a broader range of issues relevant to particular organisations, for example the issue of domestic violence in GGHB.

However, the dominance of the biomedical paradigm, and of a negative, individualised and treatment orientated concept of health, reinforced by the power of professionals and the functional differentiation of the organisations, hindered the comprehension and perceived relevance of a holistic model to organisational practice. This was apparent in the interpretation of the Policy by departments as being restricted to personnel and health care issues in the case of SRC and GDC and the perceived lack of relevance of a social/holistic model to the operation of the organisations.

In a similar way the category 'women' invoked in the development of the Women's Health Policy also conversely acted as an enabler and a barrier to its implementation. 'Women' as a category acted as an important political rallying point for the development of action, evident in the fostering of interest and the commitment to sustained campaigning for a number of years. It also provided a lever for introducing debates on gender inequality into the organisations, for the adoption of the Policy and the development of organisational women's fora to oversee its implementation. However, a number of problems emerged in relation to the representation of 'women' and the ability to achieve change within organisations.

Firstly, the category 'women' represented in the Policy consists of a homogenised view of women rather than reflecting the diversity of women's experience by class, disability, ethnicity, sexuality or age. As such, the 'problem' to be addressed is located in the presumed commonality of experience relating to biology and the related 'social role'. The concern that the Policy should represent 'all women' led to the absence of the specific needs of some women, for example issues relating to poverty, race and class. Secondly, the imposition of a 'man/woman' frame, and the linking of gender roles with biological sex can be argued to limit the possibility for transformative change in failing to acknowledge the social construction of those gender roles. In turn, this can be linked to the development

of an 'us and them' scenario, frequently highlighted as producing a defensive response within organisations.

Additional impacts of the labelling of the Policy as 'women's' can be seen in the perceived marginalisation of the Women's Health Policy and the women's organisational fora within the organisations, due to the gendered nature of organisations and the position of the category 'women' within the dominant discourses as subject 'other'. The Women's Health Policy, as with all policies for gender inclusion, presents a challenge to the existing order and practice within organisations and as such it is unsurprising that they are frequently met with resistance. However, the dilemma presented here is the question of how else change can be achieved. The Women's Health Policy and the development of women's organisational fora were necessitated due to the exclusion of an acknowledgement of gender issues within the mainstream, and yet the establishment of separate policies and structures can perpetuate that marginalisation. It may be possible to derive solutions to these problems by considering the role of power and agency.

The analysis presented within the previous chapters highlights the theme of power and agency in a number of ways. Firstly, the agency of individual women with access to power or those in positions of power was seen as vital to the successful implementation of the Women's Health Policy. The importance can be seen in the range of action resulting from the adoption of the Policy as highlighted previously. However, against this positive element, the relative lack of power of those seeking implementation of the Policy has been presented as a fundamental barrier to the implementation process. Major obstacles to a policy such as this and to multi-agency working in general are: the relative absence of women in senior decision-making positions; the power of the professions and departments; the presence of vested interests in retaining autonomy; and the status quo within organisational structures generally.

Aside from the development of women's fora within GGHB and GDC which were seen by some interviewees as positive in enabling debates on women's health to take place within the organisations, organisational structures were most commonly invoked as a barrier to the implementation of the WHP, indeed to policy implementation in general. Additional

issues raised include the gendered nature of organisations and the relative absence of women in decision-making positions, which relates to the relative lack of power of those advocating the implementation of the Policy to challenge or inform the dominant discourse within the organisations.

This links closely with the issue of organisational cultures which were largely seen as barriers to the implementation of the Policy. Glasgow as a city was characterised by a number of interviewees as having a particularly reactionary 'macho' culture, which many felt was so ingrained that it was taken for granted. Against this context, the adoption of a Women's Health Policy and development of women's structures within the organisations can be seen as significant achievement. However, influencing the culture of an organisation and making clear its gendered nature is not an feat achievable in the short term. The women involved in the implementation of the WHP have responded to this situation through identifying opportunities and seeking to build alliances within organisations and at a national and European level. The importance of having women in senior positions involved was identified by many interviewees. What was as, if not more important, however, was their interest, enthusiasm and commitment to developing action. In addition, and in common with the literature on gender inclusion policies, the findings of this research suggest that implementation would have been further enhanced by: having clearer goals; designated worker time; monitoring and review; organisational support; and adequate resources.

7.4 Aim 3: Processes of multi-agency working

Multi-agency working has been characterised as central to the development and implementation of the Women's Health Policy, and was perceived to be both an enabler and barrier. Multi-agency working was frequently cited by Women's Health Working Group members as being an important lever in the development and adoption of the Policy. The WHWG offered its members a supportive environment, the opportunity to 'network' and exchange ideas. The development of the Policy by this multi-agency group was also perceived by some to provide a lever for its adoption, although in some cases this was due to the existence of rivalry between the organisations rather than a genuine spirit of co-operation. Barriers identified relate to the issues discussed previously in relation to

cultural and power differences between professions, organisational structures, boundaries and remits within the Women's Health Working Group itself, and the relative lack of power and marginalisation of women's issues and structures within the wider organisations. In addition, the possibility of action or change occurring at a local level within organisations tightly controlled by national policies and agendas is arguably limited.

It is interesting to note that despite highlighting the above issues, very few interviewees characterised the Women's Health Working Group or the Women's Health Policy as an example of multi-agency working. Two related issues emerge here. Firstly, the perception of what multi-agency working is; and secondly, the apparent lack of internal ownership of the WHP within the organisations. The Women's Health Policy and its related fora were a largely voluntary initiative, without a prescribed remit or statutory requirement and without authority or responsibility relating to resources. Its lack of identification as an example of multi-agency working may have resulted from its implementation not being seen as a formal responsibility or part of the roles of many of the people interviewed. With the exception of GGHB (but not the NHS Trusts), the lack of authority, lines of accountability or formal systems for monitoring and review appear to have resulted in a lack of ownership of the Policy. Consequently, whilst attempts were made to work within the formal structures of organisations, the relative lack of power and authority of the women's fora to make decisions affecting the broader organisation limited the potential for implementation or multi-agency working.

The implementation process and the enablers and barriers associated with multi-agency working, have been argued to be the same between organisations as within organisations. This points to the importance of power and agency, and of culture, language and interests played out within the framework of structures as both the fundamental barrier to multi-agency working and the required locus for change. New structures can be established, but without any change in the dominant culture, the potential for transformation is arguably limited.

7.5 Central Themes

From the above discussion of the findings relating to the research aims, power and agency have emerged as central themes relating to both the implementation of the Women's Health Policy and to the process of multi-agency working. Due to the position of 'women' as 'other' within dominant discourses, this impacts on the ability to define 'women's' issues as important. However, agency has been central to the development and implementation of the Policy, and indicates the importance of creating alternative discourses in order to achieve change. The analysis presented here therefore points towards the importance of increasing the participation of women in positions of power to influence the dominant discourse within organisations as being central to achieving change. Consideration of the construction of the category 'women' is also of vital importance in influencing the direction and potential for change. The location of power is also central to the potential to implement a social/holistic model of health, and for effective multi-agency working.

7.6 Policy recommendations

Four related issues emerge from this analysis with regard to recommendations for future developments: the consideration of 'problem representation' in the development of policy proposals; the consideration of 'strategy' in implementing proposals; the need for a supportive and co-ordinated policy framework across all scales of government; and the role of education and training.

7.6.1 Problem representation

Following Bacchi (1999) consideration of the 'representation' of 'social problems' within policy proposals are of importance because the way in which the problem is represented will inform the suggested interventions and the ultimate implementation of policy proposals. This consideration of 'problem representation' is arguably as important in the design stage of policy as it is to analysing policy process and outcomes. Given the dominance of the biomedical paradigm, and the location of 'women' as 'other' within dominant discourses, this suggests the need to challenge essentialist notions of 'women' and highlight the social construction of 'women's' issues as a means of acknowledging the

potential to change inequality. Related to this is the need to reclassify 'women's' issues as 'social' issues within mainstream discourse.

7.6.2 Strategy

In relation to strategy, the research has demonstrated that, whatever the associated trials and tribulations, action on women's health progressed much more easily following the establishment of the Women's Health Working Group and the development of action 'inside' the system. In addition, the research suggests that work progressed best in the presence of key committed individuals with access to power and 'women's issues' as part of their remit, and in the context of tangible topics or projects. Weaknesses emerged in the ability to translate this action beyond a core group of individuals. The research presented here suggests the need to focus attention on developing strategies to increase the potential for change. Amongst these are the need for a multi-agency co-ordinator to negotiate action and co-ordinate work across the organisations in conjunction with designated workers within organisations to build alliances within departments, in order to develop networks as a means of increasing the scope for implementation beyond a core group. Related to this, it is argued that there is a need to develop identifiable goals and suggested action rather than leaving organisations to interpret these for themselves. This would help 'sell' the possibility of change and circumvent the tendency for inaction. Such co-ordination should be matched by designated time being made available for key individuals to pursue the implementation within their organisations. These developments would also provide the opportunity for monitoring the extent to which policy objectives were being achieved.

7.6.3 Co-ordination

The third recommendation concerns the need for a supportive and co-ordinated policy framework. The Women's Health Policy developed as a voluntary collaboration and was hindered by a lack of mandate within over-burdened and resource stretched statutory sector organisations. In addition the introduction of increased competition for resources within the public sector is not always conducive to co-operative working (unless bidding for funds brings organisations together). Multi-agency working is increasingly being advocated as a desired approach, but commonly without guidance and the appropriate legislative changes

to facilitate the process. A number of changes have taken place since the period of analysis which indicate that this situation is beginning to change, particularly in relation to funding arrangements between health and local authorities. However a range of initiatives exist at a variety of scales arguably seeking the same ends but not linked together. At a national level there is the Green Paper on 'Working Together for a Healthier Scotland' (1998) and the development of a partnership approach in Health Action Zones, which appear unconnected to the European and city level Healthy Cities Project. In addition, operating in Glasgow are the Glasgow Healthy City Project and the Glasgow Alliance, two separate structures ultimately seeking similar goals (health creation and social inclusion respectively), but using different language and terminology. To a certain extent there appears to be a problem of such initiatives continually seeking to 'reinvent the wheel' rather than building on experience. There is a need for multi-agency co-ordination, and for the co-ordination of policy initiatives at local, national and European levels.

7.6.4 Education and training

Finally, problems of differences in professional language and terminology, power and status, and within and between organisations suggest that these require change. It is therefore recommended that a more holistic approach be taken to the education and training of professionals, for example medical and nursing staff, social workers, transport planners, housing officers, teachers, planners and economists to reduce problems of conceptual barriers in working to create health. For example a component part in the training of professionals could include sessions exploring the multi-faceted range of factors that contribute to health creation and the roles and responsibilities of the various organisations and professions in relation to this.

7.7 Issues for future research

This research has highlighted a number of issues relating multi-agency working in the context of implementing a 'women's' health policy. In focusing on a single case-study, the research contains an in-depth analysis of the processes associated with this particular case, and highlight a number of issues that would be worth exploring in a comparative context. In addition, this analysis examines multi-agency working within a voluntary arrangement,

and there is scope for examining whether the same processes, enablers and barriers exist to promoting gender issues in statutory or incentive led initiatives. It would also be useful to assess the relative 'success' of policies which are labelled 'gender' policies in comparison to 'women's policies'.

The research has highlighted the importance of language, culture, power and agency in the implementation process and multi-agency working. An explicit discourse analysis was not intended within the analysis, but the research findings suggest the scope for further analysis using this framework.

7.8 Final note

This research has analysed a range of action in relation to women's health in Glasgow, which has developed against a context of considerable constraints. Such action would arguably not have occurred without the development of the Women's Health Policy, and is testament to the determination and commitment of a number of women in the city in striving to improve the health and well-being of women. It is hoped that this analysis can inform future action and lead to the further achievement of that core aim.

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WOMEN'S HEALTH POLICY for GLASGOW



WOMEN'S HEALTH WORKING GROUP
GLASGOW HEALTHY CITY PROJECT

**Produced by the Glasgow Healthy City Project
Women's Health Working Group**

*The Women's Health Working Group includes representatives
from the following organisations;
Strathclyde Regional Council, Greater Glasgow Health Board,
Glasgow District council, Glasgow University, Natural Childbirth Trust,
Scottish Aids Monitor, One-Plus, Clydeside Women's Health Campaign,
Scottish Trade Union Congress, Glasgow Council for Single Homeless.*

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Principles of the W.H.O's Healthy Cities Projects

Equity in Health
Community Participation
Partnerships for Health
Health Promotion
Primary Health care
Research for Health
International Cooperation

Foreword

"The main aim of the Women's Health Policy is to improve the health and well-being of women in Glasgow'. This document has set out recommendations as to how that aim can be met in a series of direct and positive ways. It has been produced by the Women's Health Working Group of the Healthy Cities project following lengthy consultation. The document is easily translated into practice and is welcomed by the main partners of Healthy Cities who have agreed to progress the recommendations within their own organisations.

It is important that all statutory and voluntary organisations recognise the need for and support the aims of this Women's Health Policy. To do this it is necessary that those involved at senior management and decision-making levels elevate women's health to a priority issue within their organisation. To this end the policy identifies awareness training for decision-makers as one of the first steps to ensure that the needs of women are addressed. This training would include issues such as inequality, position of women within the organisation and changing of attitudes towards women.

In translating the policy into practice it is also important for each organisation to set up or identify a forum which will oversee the implementation of the policy. Finally, the policy described below is written in the form of general guidelines; it is expected that each organisation will use this document to develop specific policies for their own interest groups.

Support for proposals for a Centre for Women's Health in Glasgow has now been agreed by the main funders of the Healthy Cities project and it is hoped that soon these proposals will be realised. We are sure that the work put into both the Women's Health Policy and the Centre for Women's Health will form the basis for expanding and developing practices which will have a real effect in the health and well being of women in Glasgow".

Sir Thomas. J. Thomson,
Chairperson
Glasgow Healthy Cities Project

Introduction

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity" WHO definition of Health 1948

This document sets out a policy to be followed whenever and wherever women's health is of concern to agencies working within Glasgow. It covers women's health in the workplace, in their private lives and in their contact with the health and other services. Specifically, it makes recommendations to create first, a new awareness about women's health and secondly, to create improvements in policies and practices which involve issues of women's health.

The need for such a document grew out of our realisation through years of contact with statutory and voluntary agencies that a women's health perspective was lacking. New initiatives and good practice *do* exist but all too often women's health needs - at whatever level - are not recognised and provided for in ways which best suit women. The Healthy Cities strategy offered a framework within which to create this policy.

The policy statement has been through a number of drafts; the final result has been achieved through an extended consultation process with a range of agencies and individuals in Glasgow. Feedback has led to revisions and the creation of the policy in its present form. The aim and objectives have universal application and we believe that all statutory and voluntary organisations should adopt them. In addition organisations should implement all the recommendations which relate to their activities.

Women's Health Working Group
Glasgow Healthy City Project

Why do Women need a Policy ?

Women have particular health needs:

- mental health problems which relate to their role in society
- physical and mental problems which relate to their biological function
- physical and mental problems which are not always sympathetically dealt with
- a risk of domestic and sexual violence

Women do not have sufficient or appropriate access to:

- knowledge
- information,
- services
- resources
- choice.

Priority issues for women's health.

- emotional and mental health
- support for women as carers
- reproductive health
- reduction in the incidence of disease
- health and safety at home and work

Aim

**To improve the health and well being
of women in Glasgow**

OBJECTIVES

- 1) To raise awareness about women's health needs and an understanding of a woman's health perspective.
- 2) To introduce this awareness into policy and planning processes of statutory and voluntary agencies
- 3) To ensure women's health needs and a woman's health perspective are incorporated into the delivery of all services
- 4) To ensure the provision of services and support specifically for women.

Recommendations *Objective 1*

To raise awareness about women's health needs and an understanding of a woman's health perspective.

- 1.1. Ensure representation of women in any decision-making about the provision of services
- 1.2. Consult with representative women's groups and organisations and take account of their views in decision-making
- 1.3. Identify within each organisation a committee or forum to ensure the implementation of the Healthy Cities women's health policy
- 1.4 Introduce awareness training for decision-makers
- 1.5 Introduce training for service providers which would include awareness of the above issues, communication skills and counselling

Recommendations *Objective 2*

To introduce this awareness into policy and planning processes of statutory and voluntary agencies

- 2.1. Incorporate gender issues into all local strategy documents of the statutory agencies
- 2.2. Develop intersectoral planning for women's health.
- 2.3. Devise a strategy for women's mental health in which the statutory and voluntary sector work together to improve self-esteem, confidence and assertiveness
- 2.4. Provide publicity for services which impinge on women's health
- 2.5. Devise alternative patterns of care in which women are not necessarily assumed to be the primary carer.
- 2.6. Ensure that the design of new buildings takes account of safety and easy access for women
- 2.7. Incorporate women's health into curricula and other educational planning
- 2.8. Incorporate women's health needs into comprehensive occupational health planning
- 2.9. Ensure that there are adequate mechanisms, including counselling and child care to support women at home and work
- 2.10. Ensure the availability of flexible hours for employees and recipients of the service

Recommendations *Objective 3*

To ensure women's health needs and a woman's health perspective is incorporated into the delivery of general health care.

- 3.1 Make available in Glasgow a Centre for Women's Health which is adequately funded and resourced.
- 3.2 Develop and support services in local communities which are easy to reach and provided at suitable times.
- 3.3 Train relevant service providers in reproductive health and sexuality issues
- 3.4 Provide childcare provision where services are provided to women in order to facilitate uptake.
- 3.5 Ensure that the provision of services encourages improved mental health for staff and consumers.
- 3.6 Develop a framework of flexible support services which can be called on as and when required by carers, and which are adequately funded and resourced.
- 3.7 Improve the conditions, environment and working relationships experienced by women in the caring professions.

Recommendations *Objective 4*

To ensure the provision of services and support specifically for women.

- 4.1 Offer a variety of stress management opportunities to women including counselling.
- 4.2 Provide adequate support and refuge for women who suffer any form of violence.
- 4.3 Develop training, support and guidance to limit stress and promote personal development for voluntary carers.
- 4.4 Develop holistic family planning and well woman services
- 4.5 Improve the quality of services and education to both the young and older woman on all issues relating to reproductive health and sexuality.
- 4.6 Ensure that abortion services including counselling are equally available in all areas and are well publicised
- 4.7 Create opportunities for women to make informed choice about obstetric and gynaecological treatment and care
- 4.8 Ensure that health promotion material is in a form relevant to women from all social groups and all ages.
- 4.9 Encourage the uptake of screening services and health checks.
- 4.10 Provide the relevant support services for women who want to have a healthy lifestyle
- 4.11 Provide a wide range of alternative services and therapies for women
- 4.12 Provide services and support for HIV positive women

Priorities for Action

Priorities for Action leading to good Practice

Each partner organisation has identified areas where good practice already exists or has made statements of intent. In addition priorities for each agency should be to undertake the following:

1. Identify a committee or forum to ensure the implementation of the Healthy Cities Women's Health Policy
2. Introduce awareness training for decision-makers
3. Make available in Glasgow a Centre for Women's Health which is adequately funded and resourced.
4. Improve inter-agency co-operation by ensuring representation on the Women's Health Working Group

Appendix 2 - Interview Topic Guide

Introduction:

- research concerns the implementation of the Glasgow Women's Health Policy as a case-study of multi-agency working.
- The focus of the research concerns the development and implementation of the original policy document within the Healthy Cities partner organisations prior to reorganisation in March 1996,
- I am interested in your own thoughts, opinions and experiences,
- anonymity and confidentiality are guaranteed.

Background:

1. Could you tell me about your employment background?
2. What does your work involve?

Health:

1. **What factors do you consider to have an effect on health? (the health of the population / the health of women)**
2. Could you tell me about your organisations involvement with the Glasgow Healthy City Project?
3. What in your opinion does the Healthy Cities concept of health incorporate?
4. **Definitions vary. What would you include in a definition of women's health?**
5. **Do you think this definition (social/holistic) is understood within your organisation?(by senior managers / by the people implementing policy / by those working in the field?)**

Women's Health Working Group:

1. Are you a member of the Healthy Cities Women's Health Working Group?
2. *Could you tell me about your involvement with the Women's Health Policy Working Group? (e.g. how long have you been a member, how often attend.)
3. *Have you any other involvement in women's health / women's issues?
4. *How does / did your involvement relate to your organisation? (official rep?)
5. *How were you involved in the development of the Women's Health Policy?
6. *What do you see as the role of the working group?
7. *What do you consider to be the strengths of the group?
8. *What do you consider to be the weaknesses of the group?
9. *Can you think of any changes / improvements that could be made?

(same questions – organisational women's fora)

Policy:

1. **What do you think is the purpose of having a women's health policy?**
2. Do you think there is a need for a separate policy?
3. **What do you see as the main objectives of the policy?**
4. **What in your opinion are the strengths of the policy?**

5. In what ways do you consider the policy to have been a success (examples)?
6. **What do you consider to be the weaknesses in the policy?**
7. **Do you think the Policy is well known within GGHB/GDC/SRC?**

Organisation:

1. Where did health come into the workings of your organisation?
2. Do you think health was seen as an important consideration?
3. **What changes have you noticed within your organisation as a result of the policy?**
4. **Has your organisation made any changes in its approach to policy development/planning or service provision? (prompts - increased collaboration, consideration of wider issues?)**
5. To what extent do you think the Women's Health Policy objectives are taken into consideration in policy development / implementation?

Implementation:

1. **How in your opinion has your organisation gone about implementing the policy?**
2. **What strategies developed to aid implementation?**
3. **What structures developed within your organisation?**
4. Who was involved / at what level within your organisation?
5. Which of the policy targets and objectives have been adopted ?
6. **To what extent do you consider these objectives to have been implemented?**
7. **What factors do you think have helped the implementation of the policy?**
8. **What factors do you think have hindered the implementation?**
9. Are you aware of any support / resistance to the policy? (From whom? For what reasons?)

(prompts - concepts of health, gender, organisational, social, cultural?)

Multi-agency working:

1. **Have you/ your department/organisation been involved in working with other agencies?**
2. **In what ways?**
3. **Can you give me any examples where this has been a success? Why?**
4. **Can you give me any examples where it has been less successful? Why?**
5. **would you consider this to be multi-agency working?**
6. **What do you understand of the term 'multi-agency'? (examples...)**
7. **Has any of this activity involved work on women's health?**
8. **Enablers/ Benefits? (examples)**
9. **Barriers/ Problems? (examples)**

Changes?

1. Can you think of ways in which the policy could be improved?
2. **its implementation could be improved?**
3. **Multi-agency working could be improved?**

**Appendix 3 – Glasgow Women's Health Policy – Draft Consultation
Document**



**WOMEN'S HEALTH POLICY
FOR GLASGOW**

A Framework for Discussion and Action

INTRODUCTION

The Healthy Cities Project is a World Health Organisation initiative designed to promote good health and prevent disease. Glasgow is the only Scottish city participating in the project, and is already in the forefront to improve health in city environments.

In 1990, Glasgow Healthy Cities Project identified several areas for action and one of these was women's health. A working group was set up, the membership of which reflected the composition of Healthy Cities itself, including representatives from Glasgow District Council, Strathclyde Regional Council, Greater Glasgow Health Board, the Universities and the voluntary sector.

The remit of this group was to bring forward proposals for an action programme on women's health for implementation in due course.

To develop such a programme the working group identified the need for an 'agreement' between the major partners of healthy Cities on areas where progress could be made, and it was felt appropriate to pursue this by seeking wide support for a Women's Health Policy for Glasgow.

To decide what should be included in such a Policy, the group turned for guidance to the 38 targets for health identified by the World Health Organisation's Health for All 2000 programme; and it follows that a Policy which could bring about improvement in the health of women in Glasgow could also provide useful benefits for men and for children.

In order that this Policy represents more than a paper exercise, it is essential to **involve both the consumers and providers of services** in its development, and to this end the Steering Group of the Healthy Cities Project agreed to launch a **consultation process** on a draft Women's Health Policy for Glasgow.

The draft has been based on a series of discussion sessions with members of women's groups from the voluntary sector who have identified particular needs as consumers which they would like to see addressed through a Women's Health Policy.

What is now needed is an opportunity for other groups of women and for the service providers themselves to comment on the draft and to indicate what they would like to see included.

The Advisory Committee of the Women's Unit of Strathclyde Regional Council has agreed to facilitate discussions within the Council as part of this consultation exercise, and other agencies will in the near future also be asked to identify similar committees within their own structures to assist in this way.

The working group, on behalf of Healthy Cities, will then incorporate the comments received into the final version which will then be submitted for adoption and implementation by the partners of the Healthy Cities Project.

Dr T J Thomson
Chairman
Healthy Cities Project

WOMEN'S HEALTH POLICY FOR GLASGOW

A Framework for Discussion and Action

The aim of this Women's Health Policy is to improve the health and wellbeing of women in Glasgow, with a focus on those most at risk, and to encourage the member organisations of Healthy Cities to be more responsive to the needs of all women.

WHY WOMEN'S HEALTH?

There are two main reasons for considering Women's Health as an issue both in its own right and as part of everyone's entitlement to good health:-

Firstly, society defines women as providing for the needs of others. This can affect their physical and mental health as well as limit their opportunities. As an apparent function of their role in society, women suffer differentially from the effects of poverty, poor housing and malnutrition. They often lack equal opportunity in employment and experience low expectations of their abilities. In addition, the provision and quality of services do not always match women's needs for support, personal development, care and promotion of good health.

Secondly, women have a reproductive system which is subject to more disorders than men's, as well as the normal function of childbirth.

PRINCIPLES

A Women's Health Policy should be based on an understanding of health within a social context as emphasised by the World Health Organisation. This view recognises that:

- health is determined by a broad range of social, environmental, economic and biological factors,
- differences in health status and health outcomes are linked to gender, age, socio-economic status, ethnicity, disability, sexuality, location and environment,
- equity of access to appropriate primary services is essential,
- health promotion and disease prevention are necessary, along with high quality treatment services,
- information, consultation and community development are important elements of the health process.

Women's Health Policy should therefore seek to:

- address women's inequality,
- encompass all of a women's lifespan and reflect women's various roles in society,
- aim to promote greater participation by women in decision making about health policy and provision of services as consumers, providers and carers,
- recognise women's rights as health care consumers, to be treated with respect in an environment which provides for privacy, both for themselves and their advocates,
- acknowledge women's rights to appropriate and accessible information and counselling in order to make informed decisions about health and health care,
- be based on accurate data and research about women's health, women's views and women's health strategies,
- identify appropriate training for appropriate workers, in keeping with the above principles,
- include the means of implementing necessary change.

PRIORITY ISSUES FOR WOMEN'S HEALTH

The following priority issues for women's health reflect the expressed needs of women in Glasgow. The principles for a Women's Health Policy form the basis for action on these issues:-

Access to Services

Emotional and Mental Health

Support for Women as Carers

Reproductive Health

Reduction in the Incidence of Preventable Disease.

OBJECTIVES

Access to Services

To develop services for women in local communities which are easy to reach and at suitable times,

To make available in Glasgow a Centre for Women's Health which is adequately funded and resourced,

To assess the physical design of buildings with a view to making them accessible to all women,

To review child care provision where services are provided to women in order to facilitate uptake,

To ensure that there is adequate and appropriate information and publicity on services which impinge on women's health,

To publicise and update the information available in the Women's Directory,

To provide catering services which supply nutritious food taking into account the specific dietary needs of all women,

To ensure that training for service providers is in keeping with the above objectives.

Emotional and Mental Health

To devise a strategy for women's mental health in which the statutory and voluntary sector work together to improve self esteem, confidence and assertiveness,

To ensure that the provision of services encourages positive mental health for staff and consumers,

To ensure that there are adequate mechanisms, including counselling, child care and other alternatives to medication for women experiencing mental health problems,

To offer a variety of stress management opportunities to women including counselling,

To research into the relationship between women's emotional health and specific life circumstances,

To provide training in communication skills and counselling for service providers.

Support for Women as Carers

To encourage alternative patterns of care in which women are not necessarily assumed to be the primary carer,

To develop a framework of flexible support services which can be called on as and when required by carers, and which are adequately funded and resourced,

To improve the conditions, environment and working relationships experienced by women in the caring professions,

To develop training, support and guidance to limit stress and promote personal development for voluntary carers,

To provide training for service providers which ensures flexibility of response.

Reproductive Health

To develop intersectoral planning, training and service provision,

To develop holistic family planning and well women services, for example along the lines of the Ballantay model in Castlemilk,

To improve the quality of services and education to young and older women on all issues relating to reproductive health and sexuality,

To ensure that abortion services including counselling are equally available in all areas and are well publicised,

To create opportunities for women to make informed choice about obstetric and gynaecological treatment and care,

To train relevant service providers on reproductive health and sexuality issues including HIV/AIDS.

Reduction in the Incidence of Preventable Disease

To make women more aware that they are as much at risk of heart disease and lung cancer as men.

To encourage the uptake of screening services.